Report

OF THE

HOSPITAL SERVICE STUDY COMMISSION

★

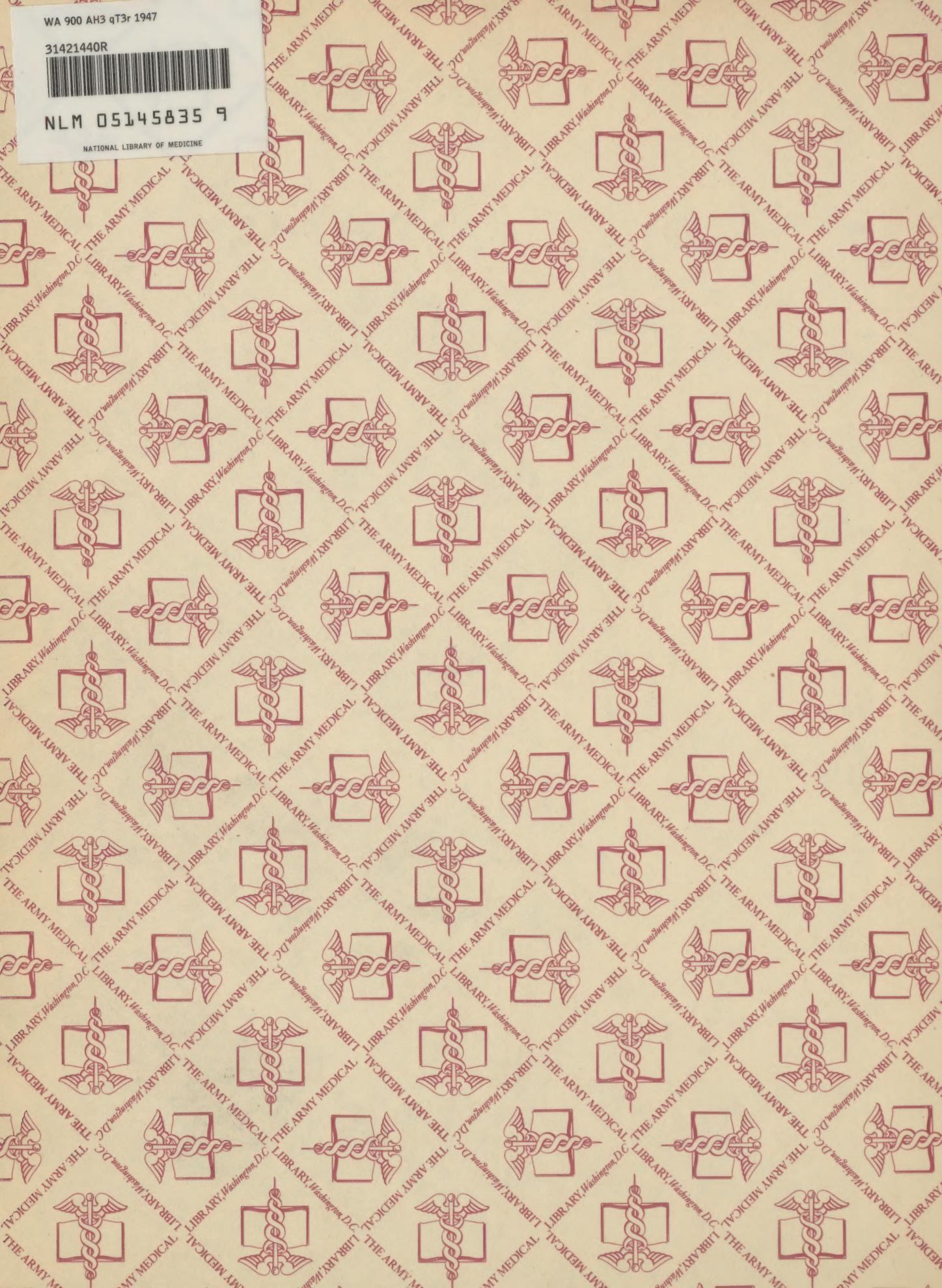
PRESENTED

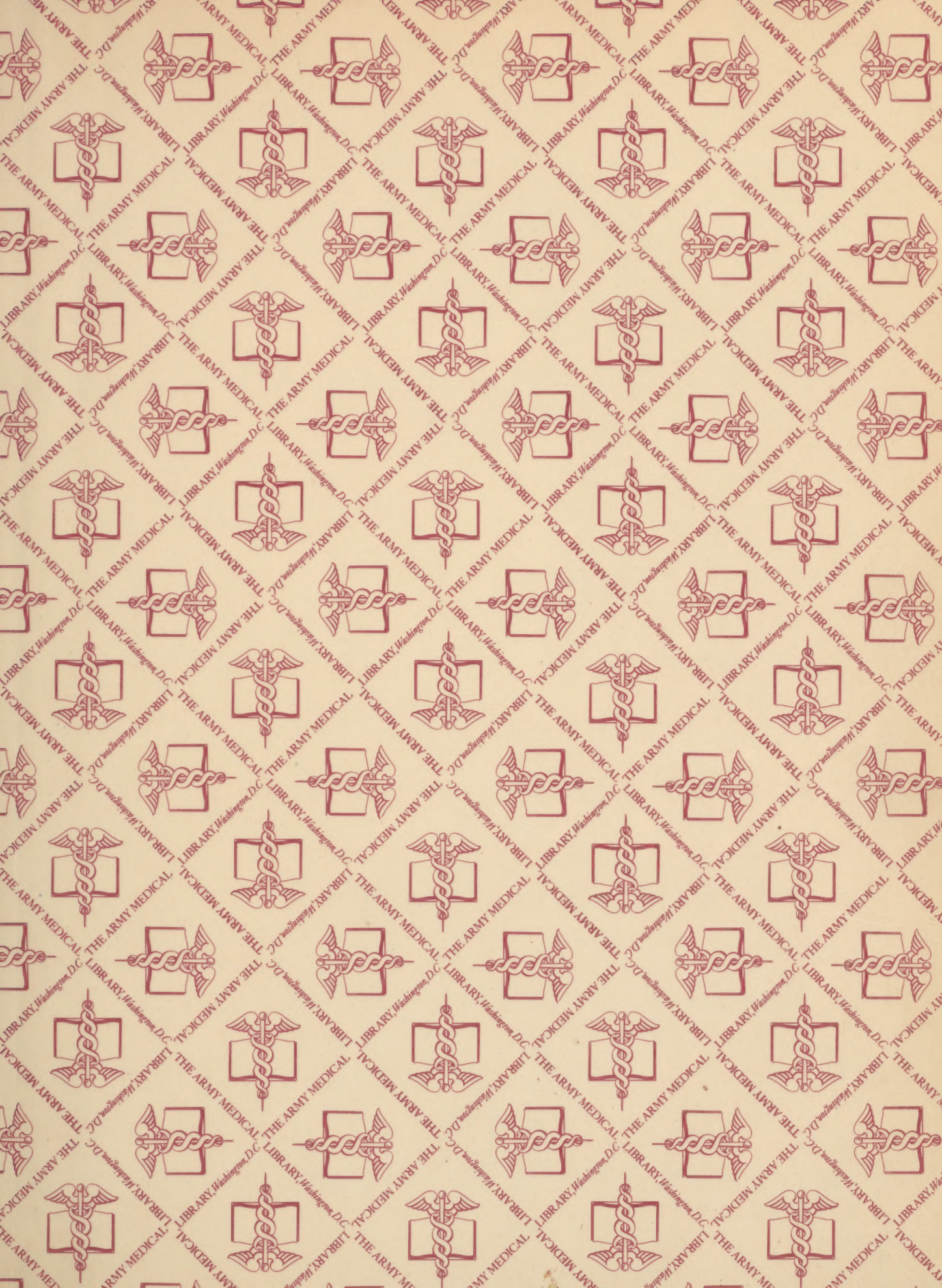
TO

THE MEMBERS OF THE
TWENTY-FOURTH LEGISLATURE
TERRITORY OF HAWAII

Pursuant To Joint Resolution No. 12, Laws Of 1945

JANUARY
1947

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Hawaii (Ter.) Territorial HOSPITAL SERVICE STUDY COMMISSION

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Pursuant To Joint Resolution No. 12, Laws Of 1945

JANUARY
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TERRITORY OF HAWAII
HOSPITAL SERVICE STUDY COMMISSION
IOLANI PALACE, ROOM 2
P. O. BOX 4067 • HONOLULU 2, T. H.

January 18, 1947

To the Members of the
Twenty-Fourth Legislature,
Territory of Hawaii

Pursuant to the terms of Joint Resolution No. 12, Laws of 1945, there is transmitted herewith the report of findings and recommendations of the Territorial Hospital Service Study Commission, appointed by the Governor on October 2, 1945.

This report is in three parts. Part I is the Commission's Report of Findings and Recommendations. Part II is a Statistical Appendix of supporting data and digests, while Part III contains the draft of a proposed bill incorporating the Commission's recommendations.

Respectfully submitted,

Charles F. Honeywell, Chairman
Charles M. Wright, Vice-Chairman
Margaret M. L. Catton
Nils P. Larsen, M. D.
Gerald W. Fisher

HOSPITAL SERVICE STUDY COMMISSION

MEMBERS OF THE COMMISSION:

CHARLES F. HONEYWELL, Chairman

CHARLES M. WRIGHT, Vice-Chairman

MARGARET M. L. CATTON

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CHAPTER I

INTRODUCTION

In accordance with the resolution adopted by the Twenty-third Legislature, the Hospital Service Study Commission submits its report to the members of the Twenty-fourth Legislature. For the purposes of clarity and emphasis, the report is divided into two parts. Part I includes a summary of the Commission's findings and the recommendations. Part II contains the statistical and other data that were collected and analyzed over a period of approximately fifteen months.

During the progress of the studies the Commission's original membership of seven was reduced to five because of unavoidable circumstances. The remaining members felt that the addition of new members who had not participated in the preceding meetings and discussions would place an undue burden on such members and, at the same time, retard the progress toward a final report. For these reasons, the present report is the product of the five members of the Commission whose names are attached.

From the beginning of the studies, no member of the Commission had any misconception concerning the complexity of the problems of medical care and hospitalization for the people of Hawaii. In addition to the time spent by each member in the review of data and in conferences and discussions with members of the technical staff and others, a total of thirty-seven meetings were held by the Commission. As the preliminary work began to near its conclusion, the Commission invited representatives of various groups and agencies to attend meetings for an exchange of viewpoints.

Whatever policies, relative to medical care and hospitalization, were adopted by the Commission each was considered to be tentative and subject to change as more facts and more evidence accumulated. But there was one general policy that was accepted and followed without change. Although the members of the Commission, in their private capacities, represent many different fields of activity and experience, no Commissioner considered himself either as a spokesman or a pleader for any particular group of people or any special interest. Thus the Commission as a whole regarded itself as representing the interests and the welfare of the people of Hawaii. In this representation, it was recognized that among the people there are specific groups whose interests merit special consideration because they render the medical and hospital services and derive their livelihoods therefrom.

A. PURPOSE OF THE STUDY

For those who read, interpret and act upon this report it is well to know that the roots of the problems that resulted in the creation of the Commission are buried deeply. The agitation for solutions may arouse passionate debates but underlying all this is a solid basis of fact from which the agitation derives its substance. Stated simply, the appointment of the Commission is a direct result of the enormous advances that have taken place in medicine and the medical sciences and the heavy costs thereof. In the light of what has happened over a century the absurdity of placing blame, be it upon the physician, the hospital, or the social worker for the existing situation becomes self-evident.

Note what has happened. Approximately a century ago medical care involved only two people - the physician, who was a general practitioner, and his patient. The hospital, as conceived at present, was non-existent; there was no nurse, no dentist, no laboratory. And then the impulse that started the revolution in medical science begins to be felt, the impulse that is called "research". More and more knowledge accumulates, too much for any one individual to acquire, and the practice of medicine becomes more and more specialized. Today the multiplications of the original general practice include not only general practice but 23 types of specialized medical practices. The hospital grows in value and its numbers multiply; dentistry develops from research; nursing, formerly an expression of neighborly helpfulness, becomes professionalized and organized. And in more recent years the professional medical social worker and other specialized groups have been

included. Where, formerly, a patient suffering from a particular condition remained in his home and received all of his care from one general practitioner, today good medical care for the same condition would call for the hospital, with its costly diagnostic equipment, nursing and other services and the skills of one or a half dozen physicians and other personnel. And all this time the stream of medical discovery becomes wider and deeper and its volume shows no sign of diminishing.

What has happened is a great tribute to the human mind. Relative abundance has replaced meager knowledge and meager facilities. And now the problem is the development of satisfactory ways and means to distribute the abundance so that its full value, so essential to human welfare, may be realized. It was this challenge that stimulated the appointment of the Commission and that defines sharply its work.

B. THE METHOD OF STUDY

There can be little respect for conclusions that are the result of hurried action or of a procedure that has no organization. Any satisfactory conclusion reached in this manner would be a product of chance and good fortune rather than deliberative thought.

The pattern of the Commission's study might be compared with the tested and accepted procedure that typifies good medical practice. The procedure is demonstrated when a physician sees a new patient. The first requirement is a careful examination; the many results of the examination are brought together and studied in order to arrive at a diagnosis. Then, and only then, is the physician in a position to recommend whatever treatment might be indicated. To arrive at a diagnosis without a careful examination or to outline a course of treatment supported only by a careless diagnosis is a violation of the principles of good scientific practice.

Following the same general pattern, the Commission's first efforts were devoted to examination. This included studies of the population; its number, distribution, and many other characteristics. It involved, also, the collection and analysis of information relative to the personnel and physical facilities for medical care in the Territory. Especially important were the studies of the economic aspects of medical care, including the evidence relative to the utilization of services, the costs to the population, the income of hospitals and physicians, and other material. Pertinent information was obtained from the many studies of medical care that have been made on the mainland over a period of years. Foreign experience was examined, legislative proposals were analyzed and other proposed or existing programs of medical or hospital care were studied.

As stated, the statistical tabulations of data and the other compiled information will be found in Part II of the report. The Commission urges strongly that, even though certain data are emphasized in Part I, the material in Part II be studied by all who are interested in the present and future of medical care in the Territory of Hawaii.

It is customary and expected, in the preparation of reports of this nature, to include a statement titled "Validity of Data". Under this heading the author or authors point out the defects or the gaps in their data and other information. The custom is a sound one and the Commission would be remiss if, in fulfilling its functions, it does not indicate clearly those decisions based upon facts and those derived from opinions or best judgments. And, in accordance with this policy, at times various alternative judgments or conclusions will be presented.

Whatever may be the criticisms of the recommendations, the Commission expresses the hope that they will be received and considered in the same atmosphere of calmness and objectivity that surrounded the deliberations preceding the preparation of the report.

CHAPTER II

THE BASES OF THE COMMISSION'S RECOMMENDATIONS

A. THE NEEDS OF THE PEOPLE

The Commission is fully aware of the fact that health is a combination of many factors. Medical sciences and services contribute enormously but there are other influences that cannot be considered as minor ones. Examples are adequate nutrition, good housing, sanitary surroundings, satisfactory economic conditions, recreational opportunities, and sound education.

There are some who contend that the primary attention should be devoted to these other factors and that medical care 1/ should be considered at a later time. It was not the Commission's function to designate "most important" or "least important" health influences. The present trend is to place medical service high in the list of needs. Under ideal circumstances all health problems might be solved at the same time; short of ideal circumstances it becomes necessary to select, arbitrarily or otherwise, the problems to be given first attention.

The principle that an opportunity to receive adequate medical care is essential to the well-being of the people was accepted without question by the Commission. It was also accepted that adequate care would necessitate a comprehensive service available and accessible to all the people for the prevention or cure of disease and the promotion of health.

There are at least four fundamental requisites to adequate medical care. They are (1) adequate personnel; (2) adequate physical facilities; (3) adequate financing; and (4) an informed public. Here, again, the Commission recognizes that there are many differences of opinion about the proper place to start improvement. For that reason each of the requisites deserves comment.

1. Adequate personnel. There are no precise standards by which the adequacy of personnel (physicians, dentists, nurses and other) may be judged. However, certain comparative information relative to physicians illuminates the situation in the Territory.

At the beginning of the war there were approximately 176,000 physicians in the continental United States. Of this number about three fourths, or 132,000, were available for service to the general public. Thus, the ratio was approximately one private practitioner of medicine per 1000 people. This ratio included both general practitioners and specialists. For the services of general practitioners it is estimated that there was one physician per 1200 to 1300 people.

The ratios and estimates apply to the country as a whole. Within the geographic areas and the individual states there are wide variations. Compared with the ratio of one physician in private practice per 1000 population, the ratio was approximately 1 to 800 in the Middle Atlantic, Mountain and Pacific areas. At the other extreme it was 1 to 1300 in the West South Central area and 1 to 1500 in the East South Central area. 2/ There is a direct relationship between the buying power of the people and the concentration of physicians in private practice. 3/ Prior to the war there was one physician to about 600 people in New York, one to 700 in Massachusetts and one to 750 in California. The comparable figure for Alabama was one to about 1700 and for Mississippi, one to about 1800.

In the light of the above relationship, what was the pre-war situation in the Territory? With a total population of 423,330 in 1940 and 346 physicians licensed, of which 334 were in active practice, the Territorial ratio was one physician in active practice per 1267 population. This takes into account the physicians employed by the plantations, the Board of Health and those employed full-time by institutions and hospitals. The distribution of physicians by counties was as follows:

1/ The phrase, "medical care" as used in this report includes the services of physicians, dentists, nurse, hospitals, etc.
2/ Alabama, Kentucky, Mississippi and Tennessee.
3/ See Table 31, Part II

TABLE 1

RATIO POPULATION TO PHYSICIANS IN ACTIVE PRACTICE, TERRITORY OF HAWAII, BY COUNTIES. 1940

	Physicians	Population Per Physician
Territory	334	1267
Honolulu County	237	1089
Hawaii County	44	1665
Kauai County	22	1628
Maui County	30	1866
Kalawao County	1	446

It should not be concluded from the above variations that each county should show approximately the same ratio. Obviously a concentration of many of the medical specialties would be expected in the medical center of the Territory, Honolulu. Assuming that the general ratio for the Territory indicates the pre-war availability of physicians' services to the total population, the position of the Territory in 1940 was 43rd in the rank of states and the Territory of Hawaii. The states exceeding Hawaii in number of population per physician in 1940 were the states of Idaho, South Dakota, North Carolina, South Carolina, Alabama and Mississippi. 4/

For 1946, with an estimated population of 519,503 5/, the number of licensed medical practitioners as of July 1, 1946 6/ was 388; of these 353 were in active practice. Thus the ratio of active physicians to population in the Territory was one physician to 1472 people. (See footnote)

The breakdown by counties of the physician-population ratio for 1946 is shown in the following table.

TABLE 2

RATIO POPULATION TO PHYSICIANS IN ACTIVE PRACTICE, TERRITORY OF HAWAII, BY COUNTIES. 1946

	Physicians	Population Per Physician
Territory	353*	1472
Honolulu County	263	1364
Hawaii County	44	1593
Kauai County	14	2508
Maui County	31	1749
Kalawao County	1	386

4/ See Table 31, Part II
5/ Board of Health Estimate, November 1, 1946
6/ Board of Health published list of licensed physicians. July 1, 1946

* Since July 1, 1946, seventeen physicians have obtained licenses in the Territory and twenty-five have applied to take the examination for licensure in Jan. 1947. Assuming these latter obtain licenses and that all will be active in the Territory, and assuming no change in population, the ratio will change to 1315 people per physician.

This ratio is such that it would be regarded as descriptive of the situation in a "poor" state. Yet the economic level of the Territory is not below that of the average state. One of the tests used as a measure of the relative wealth or income in the states is the measure of the per capita income. Preliminary estimates for the Territory of Hawaii indicate that per capita income payments to all individuals in the Territory for 1945 were approximately $1121. This placed Hawaii 20th in the rank of the states and the Territory of Hawaii, and regionally closest to the level of the Central States; exceeding the Southeast, Southwest, Central and Northwest regions, and being exceeded by the New England, Middle east and Far west regions. 7/

Recognition must be given to the fact that for the most part in the rural areas of the Territory the population clusters around the plantation mill town and is rarely dispersed and isolated as in rural areas elsewhere in the states. Also there has been operating in the Territory over many years a highly developed system of plantation hospitals and outpatient dispensaries serving plantation and non-plantation alike, affording such convenience as to make possible a larger quantity of medical service per physician than ordinarily is achieved by physicians in private practice.

In that part of the report devoted to specific recommendations one other aspect of adequate personnel will be considered. This relates not to numbers but to training and qualifications of those who provide the medical services.

2. Adequate physical facilities. The hospital is the chief physical facility for the provision of medical care. And in the various states the number of hospital beds per 1000 population is a fairly accurate index of economic well-being.

Intensive studies of hospital needs have been and are being made in many of the states. The standard that is accepted generally is a need of 4.5 general hospital beds per 1000 population. For continental United States there were 3.5 beds in 1940. But here, too, the range is a wide one, according to the various geographic areas as shown by the following table:

TABLE 3

Area	Bed Per 1000 Population
New England	4.8
Middle Atlantic	4.4
Mountain	4.3
Pacific	4.3
East North Central	3.6
West North Central	3.5
South Atlantic	2.8
West South Central	2.3
East South Central	1.8

Within the areas the differences are greater. Thus, among the more populous and wealthy states, Massachusetts had 5.5 beds, California 4.5, and Michigan 4.4. At the other extreme were Alabama with 1.8, Arkansas 1.7 and Mississippi with 1.6. And again the distribution of these facilities conforms to the pattern of high or low purchasing power.

It was said that, according to the data on the number and distribution of physicians, the Territory would be classified as comparable to the poorer states. Is the same picture repeated for hospitals? The answer is, "Decidedly not!"

The study of hospital facilities included a preliminary analysis of a detailed survey schedule that was completed for each hospital. The analysis provided the data immediately necessary for the use of the Commission. The further use of the schedule will be discussed later.

In 1946 a total of 46 general and allied hospitals in the Territory reported 2422 beds. (This

7/ See Table 20, Part II

figure includes maternity, pediatric and orthopedic hospitals; it does not include convalescent and chronic hospitals and nursing homes, tuberculosis, mental and leprosy hospitals). The ratio, based upon an estimated population of 519,503, is 4.7 beds per 1000 people. This figure by itself would classify the Territory among the well-to-do states. However, it should be pointed out that many of these reported beds are located in small, wooden buildings hardly classifiable as "hospitals". Close analysis shows a definite need for a comprehensive rural hospital program. For the various islands the ratios are as follows:

TABLE 4

RATIO OF GENERAL AND ALLIED HOSPITAL BEDS PER 1000 POPULATION. 1946

	Beds	Ratio
Territory of Hawaii	2422	4.7
Honolulu County	1215	3.1
Hawaii County	589	8.4
Kauai County	171	4.9
Maui County, excl. of Kalaupapa	451	8.3

Late during the course of the Commission's studies a significant action was announced that has a definite bearing on the subject of facilities. The Congress enacted legislation appropriating funds for the construction and improvement of hospitals. 8/ The legislation requires the appointment of a Hospital Council in each state and territory to advise a designated government agency in a study of hospital needs. The study is intended to serve as a basis for the preparation of a "master plan" for the improvement of existing hospitals and for the construction of new hospitals, convalescent nursing homes and health centers. It need not be stressed that the study and the plan involve not only the number of hospital beds but also the other facilities in hospitals - surgical, obstetrical, x-ray, etc. The legislation was endorsed by the American Hospital Association and the American Medical Association and it is likely that the future construction or expansion of hospitals will follow an orderly process rather than the haphazard growth of the past.

In accordance with existing federal legislation the Governor of the Territory has designated the Board of Health as the governmental Administrative agency and the members of the local Advisory Council have now been appointed. It is expected that the preliminary work of the Hospital Study Commission will serve as a basis for the Territorial hospital plan. The schedules, previously mentioned, that were submitted by the hospitals have been sent to the American Hospital Association for statistical processing preparatory to the development. It is fortunate that the schedules and the statistical data will be available to the Board of Health and to the Advisory Hospital Council at a much earlier date than would have been the case if the Commission had not made its collection.

Here then is a development that has occurred since the adjournment of the Twenty-third Legislature. There is now a reasonable assurance that over a period of time the physical facilities, as typified by hospitals, nursing homes and health centers, will be constructed and improved to meet the needs of the people. This fact in itself makes the Commission's recommendations doubly important. Hospitals, nursing homes and health centers can be dynamic institutions in their effects upon the lives of people; they can also be static monuments. Whether they are the one or the other depends upon the accessibility of their services to those who need them and the type of personnel conducting them.

8/ Hospital Construction Act, Public Law 725, 79th Congress, 2nd Session, A digest of this legislation is presented in Part II.

In terms of the immediate problem, therefore, the Commission concentrated much of its attention upon the subject of adequate financing. The question before the Commission was a very realistic one. Given certain personnel and facilities in the Territory of Hawaii now, located as they are now, how may they be utilized to the best advantage now? It is anticipated that the same question must be asked and answered year after year as facilities improve, as personnel increase and as new scientific discoveries are tested and proved effective. As will be shown later, adequate financing may result in extremely important by-products, not the least of which may be the influence in improved service and on the level of public information and education.

3. Adequate Financing. The public's interest in medical care is concentrated upon the subject of financing. There have been many polls of public opinion and time after time the public has indicated its need and demand for protection against illness as a contributing cause of insecurity. 9/ Some of the polls have presented questions that are confusing and that lend themselves to different interpretations. Regardless of how the questions are asked the public demand expresses itself. There must be more than an emotional reason for the consistent response.

The Commission assumed that the general impact of illness upon the people of Hawaii does not differ greatly from the effects upon the population of the mainland. There is a mass of information that has been derived from studies in the states and the available data have been used by the Commission. 10/ To have engaged in comparable minute studies of illness, services received and costs would have been time consuming and extremely costly. Fortunately there are in the Territory collections of valuable data and these were analyzed as a check on the general assumption that has been expressed above. References will be made to the data later in this report.

It has been said that illness is an important contributing cause of insecurity. The annual experience of an average 1000 people demonstrates this fact. Among the 1000 there will be 470 who report no illness; they are the ones who are or think they are healthy. Undoubtedly there are in this group a certain number who suffer from conditions of which they are unaware. The experience of the remaining 530 people is significant. By far the largest group, 322, report only one illness; 137 experience two illnesses; 48 report three illnesses; 16, four illnesses and 7, five or more illness. 11/

It is regrettable that statistics are such a cold medium of expression. There is nothing cold about the occurrence of illness and the chief fact that emerges from this set of figures is that no one knows in advance whether the year will find him among the 470, the 322 or the much less fortunate 16 or 7.

There is ample evidence of the variations of illness according to the age and sex. But one of the most significant variations occurs among the different income groups. Comparing families in the high and low income groups, families with annual incomes over $5000 and those with incomes below $1500, those in the latter group shows more illness and more days of disability. 12/ As a further variation of illness, no one can predict its extent or severity for an individual or a family. In the preceding statistics one of the 322 people may suffer from a minor condition, another may be ill for the entire year.

Here, then, is the first element of insecurity. Though the public may know little and care less about statistics, the expression "if I don't get sick" is commonly added to almost every statement about future hopes or ambitions. As so often happens, the public has its own way of summarizing a background of broad experience.

Tied to the unpredictability of illness is the unpredictability of costs. The results of studies made in 1929 and 1941 show generally comparable results. The costs for 1929 are used not with any thought of portraying the costs that existed in 1945 or 1946 but rather to show the relative differences. For example, in 1929 the average cost of all medical services (physician, dentist, hospital, nurse, drugs, etc.) for families according to different annual incomes was as follows:

9/ A compilation of the various polls appears in Part II of the report.
10/ The studies include those made by the Committee on the Costs of Medical Care (1928-31), the National Health Survey (1935-6), The American Medical Association (1939), the Department of Commerce and Labor, 1940-1941-1943, The Blue Cross Hospital Service (through 1945), and others.
11/ See Table 50, Part II
12/ See Table 49, Part II

TABLE 5

Family Income	Costs
Under $1200	$ 49.00
$1200 to 2000	67.00
2000 to 3000	95.00
3000 to 5000	138.00
5000 to 10,000	249.00
Over 10,000	503.00
Average, all families	108.00

It might be thought that higher fees paid by those in the higher income groups account for the higher costs. But an analysis of the services received by each income group shows that, with the exception of hospital days of care received by the "under $1200" group, as income increases services likewise increase. Compared with the "under $1200" group those in the highest income group received about two and one half times the number of physicians' home and office services and about five times the dental care.

The average family cost of $108 was divided among those who provided the services as follows:

TABLE 6

Item	Percentage
Physician	39.8%
Hospital	13.0
Nurse	8.1
Dentist	18.5
Drugs	12.9
Refractions and Glasses	2.5
Secondary Practioners	2.2
Other	3.0
All	100.00%

The full table showing the division of the average costs for each income group appears in Part II.

Thus far the picture is one of averages. It is when the variations in costs within each of the income groups are examined that the second element of insecurity appears in harsh outline. Some families experienced no costs and others were burdened with costs that when compared to the family income were enormous. The study of variable costs is shown in the following table:

TABLE 7

VARIATIONS IN FAMILY EXPENDITURES ACCORDING TO INCOME GROUPS AND CLASSES OF COSTS, 1928-31

Costs	Under $1200	$1200-2000	$2000-3000	$3000-5000	$5000-10,000	Over $10,000	All
Under $20	48.8%	34.4%	25.2%	16.7%	8.4%	2.6%	28.7%
20 - 60	30.6	34.5	29.2	23.6	19.6	9.1	29.1
60 - 200	15.8	24.0	33.0	40.6	36.1	30.2	28.6
200 - 500	3.8	6.0	10.4	14.7	23.3	25.3	9.9
Over 500	1.0	1.1	2.2	4.4	12.6	32.8	3.7
	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

That illness has no respect for family incomes is evident. However reasonable may have been the charges for families with incomes under $1200 or under $2000 a percentage of such families experienced costs higher than $500. Among all the families, with an average annual cost of $108, there were 58 percent that expended less than $60. At the other extreme there were 10 percent that experienced costs higher than $250. And the latter families, the unfortunate 10 percent, paid about 41 percent of the total costs. To those families the average of $108 would mean nothing except as it provides a measuring rod of their misfortune.

The foregoing experience is that of a single year. It repeats itself year after year, involving more and more families. This fact alone accounts for the widespread public interest in medical care and it accounts for the public urge as expressed in the polls. There is little evidence that the public wants cheaper medical care; there is abundant evidence of the public's desire for protection if and when illness and its accompanying costs are experienced.

B. GUIDING PRINCIPLES

Based upon the review of the occurrence of illness and its costs the Commission adopted the following series of guiding principles. Some that are supported by the preceding information are presented without further comment; others merit some discussion. Taken as a whole they serve as the foundation upon which the Commission bases its recommendations relative to adequate financing.

1. Without an organized system of payment the receipt of medical care by individuals and families varies in general according to ability to pay rather than according to need.

This statement has in it no implication of criticism, either of medical personnel or institutions. It is probably true that anyone in the Territory with an urgent need can obtain medical care regardless of his income. While it is the tradition of medicine to provide service, the very complexity of medical care creates obstacles for self-supporting individuals and families. Even though physicians may be willing to provide care at very low rates or free, their portion of the total costs amounts to approximately forty percent. And those individuals and families that comprise an overwhelming majority of the population, the self-supporting group, should not be placed in a position where the dignity of self-support is maintained at the expense of health.

It is unfortunate that the confusion that attends so many discussions of medical care appears to place physicians in a defensive position. Because of that defensive position the profession often demands proof that an unmet need exists. The debate that ensues usually makes up in vigor what it lacks in logic. There is a tendency to stress the draft rejections and to point to the evidence of other physical examinations as indicating unmet needs. And these arguments are countered by statements that many people are ignorant of their physical defects or do not consider them important enough to make the sacrifices that are necessary to obtain corrections. The debates develop into a form of circular motion that accomplishes only a strengthening of antagonisms.

The problem is clarified greatly when it is viewed in its economic and psychological aspects. It has been shown that families with no income or a bare subsistence income, families that must

live on less than $1200 per year, experience more days of hospital care than other families with incomes up to $5000 per year. Considering the difficulties of admission to hospitals, there are few who would contend that the needs of the low income families are imaginary. At the same time the resistance of such families to charity is low.

Self-supporting families do not welcome the imprint of charity. The services of physicians and hospitals are regarded as bills to be paid from savings or from current or future income. Hence, if a service is not regarded as extremely pressing, if a need can be postponed, there are economic and psychological incentives to postpone. The fault does not lie with the physician, neither can it be assigned to the hospital. But the fact remains that among families with incomes above $1200 the use of the hospital increases according to income unless there is an organized system of payment. And as far as physicians are concerned, the use of their services by all income groups is related directly to income.

Any doubt concerning the validity of the above paragraph has been dispelled by the grim evidence of October, 1946, some six weeks after the beginning of the sugar strike. In a news item 13/ the statements of representatives for the medical profession and the hospitals relative to certain of the effects of the strike were quoted. The medical spokesman said, "The extremes in the drop-off of patient attendance at doctors' offices range from 20 to 40 percent with a 25 percent average through all wage and income groups. There is a marked tendency of patients to withhold from medical attention as long as they can." And Queen's Hospital was said to have reported a decrease of ten percent of male and twenty percent of female admissions. The source of the hospital information is quoted as saying that, "Many of them (people) suffer and some of them die for inability to pay for proper hospitalization".

The percentages quoted may have been based upon accurate studies or upon rough estimates. While there might be differing opinions about the percentages, there can be little question about the sensitivity of the medical barometer to economic changes.

2. The economic burden of illness cannot be predicted for an individual or for a family over a specified period of time but can be predicted with reasonable accuracy for large groups of individuals and families.

In this principle the question of "reasonable accuracy" is the pertinent one. The Commission will comment on this question at some length in connection with its specific recommendations.

3. The cost of medical care lends itself to equitable distribution over groups of individuals and families and over designated periods of time.

This statement and the preceding one provide the basis for an economic attack on the problem of medical care. The data that have been presented show that during a year some people experience no costs and others experience high costs.

As an illustration, there are about eight appendicitis operations in a year among an average 1000 persons. No one can predict which eight people will be affected. Probably the costs of each case will vary but on a "pay-as-you-go" basis the total costs are borne by eight persons. If, however, the total cost is $1600 and each of the 1000 persons contributed to a common fund the cost per person per year would be $1.60 plus the costs of administration.

The principle of applying an average cost is one with which the American public is well acquainted. Whether, in this case, it is called "organized payment", "prepayment" or "health insurance" makes little difference. Fundamentally this form of insurance, like all others, is a social device whereby groups of people by sharing the risk of an unpredictable occurrence protect the individuals within the group.

4. The costs of medical care should be distributed over individuals and families in accordance with their ability to pay.

This guiding principle is intended to emphasize the point that individual and family needs are the primary concern in any system of organized payment. The Commission visualizes organized payment as a means of meeting the needs for whatever services or types of services may be included in the system. Without organized payment families in the lower income groups, if they are to meet their needs, must spend a higher percentage of their incomes even though the actual amounts, in terms of dollars, may be less. Studies that have been made show medical expenditures

13/ Honolulu Advertiser - October 11, 1946

approximately four percent of all consumer purchases. Those in the low income groups averaged nearly five percent while the expenditures of those in the higher groups were less than four percent. Thus, there is a penalty and, extremely important, it is that most desirable social unit, the family, that is penalized most heavily.

5. In any system of organized payment no emphasis should be placed upon a means test, as indicated by individual or family income, when medical care is sought.

This guiding principle is a corollary to the one regarding payment in accordance with ability. All physicians would resent any implication that their services vary according to the income of their patients. The resentment is a justifiable one. Therefore, no system or organized payment should permit even a question to be raised in the minds of the public regarding any relationship between the quality and quantity of service and income. When an individual or family requires medical service, the request should not be accompanied by any presentation of evidence (a means test) showing, for example, whether the annual income is $1200 or $3000 or $4800. One exception to this rule will be discussed when the matter of the physician's fees or income is considered. But meanwhile the guiding principle is emphasized because the Commission is vigorously opposed to the development of anything that has even a remote resemblance to one system of service for the poor and another for the well-to-do.

6. In any system of organized payment the personnel and institutions that provide the services should be remunerated adequately.

It goes almost without saying that no system of organized payment can be successful if it functions, even partially, at the expense of those who provide the services. The Commission assumes that the people of Hawaii would express themselves as unanimously in accord with this principle. In its recommendations the subject of remuneration will be presented as a part of the subject of costs.

7. In any system of organized payment provision should be made for the continuing education of professional participants and the public.

Previously the statement was made that the volume of medical discovery shows no sign of diminishing. If improvements in medical care are to reach the people it must be through the constantly increasing knowledge of the professional personnel. It is a trite saying that the physician must be a student of medicine from the time he enters medical school until he retires from practice. If he continues to be a student the means of education must be organized and financed. Only in this way can the physician's knowledge be maintained at a high level.

The Commission regards this aspect of medical care as a very important accompaniment of organized payment. And it regards the continued improvement of personnel as a justifiable charge within a system of organized payment. Too little attention has been given to this subject in terms of positive and consistent action. Continued education of profession personnel calls for a long range program that, in its potential benefits, has immeasurable value.

The education of the public is regarded, also, as a responsibility of an organized system of payment. The full benefits of medical care can be realized only when there is an informed public. Therefore, an organized system of prepayment should integrate its own educational efforts with those of all other educational agencies in the community to the end that the public shall be informed.

8. In any system of organized payment the preventive health services should be emphasized.

The principle is closely related to professional and public education. It is a significant fact that prevention starts with the public. In some cases the public acts as a group by adopting laws and expending funds to prevent or control specific diseases. In other cases the only successful method of applying the principles of prevention must be based upon the knowledge and the action of the individual. It is not feasible, for example, to legislate against many of the nutritional and other conditions that are either partially of wholly preventable. The method of attack must be educational but the education must be supported by making the services available.

One general aspect of preventive medicine should be stressed in any system of organized payment. Early diagnosis and early and adequate care have an immense value. The line between preventive medicine and curative medicine is a very artificial one. For example, when surgery is

indicated in a condition such as appendicitis or cancer an early operation by a qualified surgeon is excellent preventive medicine. Therefore, in a system of organized payment it is vital to the cause of good medical care that any barriers to early diagnosis and treatment be reduced to a minimum.

9. In any system of organized payment institutional standards should be developed and the adequacy of institutions should be in accordance with professional needs for rendering good medical care.

The guiding principle was adopted by the Commission prior to the enactment of the hospital legislation previously mentioned. There is now a reasonable assurance that the future development of hospitals and health centers in the Territory will be based upon specific needs. In the concept of the Commission hospitals are of the nature of public institutions. Their growth should not be a purely competitive one but should be in accordance with community needs. For these reasons the work of the Board of Health and the recently-appointed Hospital Advisory Council in planning for future hospital expansions is a vital part of any system of organized payment.

10. To summarize what has been presented thus far, any system of organized payment should demonstrate the following qualities:

a. Medical Soundness, i.e., the care provided should serve as a substantial attack upon the problem.

b. Social Soundness, i.e., the inclusion in the system, without a means test, of those income groups for whom payment, if it were made when medical care is needed, would constitute a burdensome economic problem.

c. Economic Soundness, i.e., the funds, collected in an equitable manner, should provide the services that are included.

d. Administrative Soundness, i.e., the services should be distributed effectively at a minimum administrative cost and under conditions that provide a reasonable maximum of satisfaction for those who provide and those who receive medical care.

11. The chief economic burden of medical care involves those illnesses that require hospital and physicians' services. Therefore, the minimum attack upon the problem, through an organized system of prepayment, should include physicians' services and hospital services for hospitalized illnesses.

There are two major reasons for the adoption of this guiding principle by the Commission. The first is the fact that approximately 50 percent of the total costs of all medical services concentrate upon those people who experience the combined services of physicians and hospitals. Therefore, to include these services would meet the requirement expressed previously in terms of "medical soundness."

The second reason relates to administration. While there is a certain body of existing administrative experience much more needs to be learned. With respect to administrative arrangements for medical care the Commission recognizes that adequate administration is the chief element in the success of a system of organized payment. To build sound administration takes time and personnel.

These are the reasons for the guiding principle that a system of prepayment should be initiated with the services limited as above. The Commission also recognizes that the limitations themselves may create certain administrative problems. There is the possible incentive to use the hospital for patients that normally would not be hospitalized. But the same incentive would be only slightly less if a comprehensive service were available. At any rate such an incentive, if demonstrated, would call for administrative measures applied in accordance with the advice and guidance of the medical profession.

Even with the limitations on the initial services, medical care that is of a preventive type should be emphasized. What has been said about barriers to early diagnosis and treatment would apply to the services that are included at the start. As one example, the services for obstetrical cases should provide prenatal and postpartum care. The Commission recognizes that this is an exception to its guiding principle that organized payment should start with hospitalized illnesses. But it is an exception that is in the interests of sound medical care.

12. The ultimate goal of any system of organized payment should be the provision of comprehensive medical services to the people.

Whatever may be the starting point, in terms of initial services, there should be progress toward the ultimate goal - comprehensive services. A statement repeated many times is that a system of organized payment should protect people against catastrophes. With this the Commission is in general accord. The difficulty arises when an attempt is made to define a catastrophe.

It might be assumed that such services as physicians' office and home calls would be excluded from any classification of medical economic catastrophes. But when the records are examined it is seen that about ten percent of families experience more than twenty-five such services in a year. Hence, home and office calls may be economically burdensome to families that are not in the low income groups.

The desirability of comprehensive services has been expressed by the public and its ultimate provision has been approved by the organized medical profession. The Commission's views concerning its values have been expressed in certain of the preceding principles, especially those relating to the equitable distribution of costs and the inclusion of preventive services.

13. In order to progress toward the goal of comprehensive medical care a system of organized payment should be expanded, within specified periods of time to include the other services.

The Commission feels that as administrative experience accumulates there will be progress toward the expansion of services. However, the progress should not be left wholly to chance or to the acceptance by someone of a hazily-defined responsibility. It is the Commission's view that, in order to insure a steady approach to the development of comprehensive care, the administrative agency or agencies be required to submit progress reports to each legislature including therein appropriate recommendations for an expansion of the program.

As a sidelight on the progressive approach toward comprehensive care, as well as an indication that judgments concerning the first and succeeding steps may differ, the recommendations in Canada are of interest. The proposed national health act offers a "two stage" approach. The first stage includes home and office care by the general practitioner, hospital care and visiting nursing service in homes. The second stage includes the services of medical specialists and private duty nurses, certain dental services, laboratory services and drugs.

14. In any system of organized payment policies concerned with the administration of and payment for medical care should be determined by the joint action of professional, institutional and public representatives. Provision should be made for professional administration of professional services.

Organized payment is a joint undertaking and everyone has a valuable stake in its successful operation. Many questions arise concerning the amount and form of payment for services and it is the privilege of no group to dominate completely when decisions are made. The members of any policymaking body should not regard themselves as holding membership to obtain special or preferential treatment for any group, be it that of industry, labor, the professions or other. The primary purpose of all is to make the system work effectively and give adequate service.

In matters that are of direct concern to the professions and institutions it is only logical that trained professional personnel should occupy those administrative positions that call for technical decisions. Such decisions, unless based upon a knowledge and understanding of a particular field of training, would engender little respect.

15. Potential sources of funds to support a system of organized payment for medical care are:

a. Individuals - employees and others

b. Employers

c. Government - National, Territorial, Local

The Commission, in its later estimates of costs, will present data relative to the amounts necessary for the services that are included in its recommendations. It would stress the point now that the above sources of funds must provide the total, whatever may be the method of collection or whatever may be the weight of the contributions from any or all of the sources.

There is another important aspect of costs that should be understood clearly. The expenditures that will be proposed should not be considered as new expenditures or "new money." A very large percentage of the total amount is being expended now. Under present conditions the expenditures, though large, are unorganized - the situation that constitutes the chief economic problem of medical care.

16. Funds from any or all of the potential sources may be utilized to pay a portion of the total included services or a portion or all of specified services, including the costs of administration.

The above guiding principle means that there is a wide variety of choice in the method and the amounts of contributions from the three potential sources of funds. As an illustration and considering government as a potential source of funds, a number of possibilities present themselves. If Congress enacts a bill that has been proposed, 14/ a subsidy would be provided to the states and territories for the medical care and relief of low income groups. This would result in a special subsidy for a portion of the population. It is conceivable, too, that government (national, state, or territorial) might earmark specific funds for the operation and maintenance of hospitals. And this would mean the utilization of funds for a specified portion of the included services.

Viewing the whole panorama of actions and proposals, it is obvious that this is the formative stage in the development of widespread organized payment. Because it is the formative stage any proposal made or any program that may be adopted by the Legislature must be broad in its concept and sufficiently adjustable to conform to future needs.

17. In its final guiding principle and as a preliminary to the recommendations, the Commission desires to focus attention upon the primary problem and upon clearly defined objectives.

The primary purpose of a system of organized payment is to diffuse the economic burden of medical care. Other objectives are complementary to this primary purpose and may be attained only if they are defined, emphasized and sought as a part of the system. Examples of these objectives are a high quality of service, including preventive service, post-graduate medical education, public education for the improvement of health, etc.

A system of organized payment can be just that and nothing more. Funds can be collected and expended without attaining any of the valuable complementary objectives expressed; they are not automatic accompaniments. If a system of organized payment is adopted and developed in the Territory of Hawaii, it will fall far short of its potential benefits if it produces only a "dead level" type of service. Even though the chief purpose must remain clear, many of the recommendations made by the Commission are intended to combine its attainment with definite progress toward the goals of improved service for the people of the Territory.

NOTE:

Relative to Propositions No. 12 and 13 on page 13, the exact degree to which comprehensive services should extend was not unanimously agreed upon by the Commission. It was the feeling that this was a matter which should be left to the future to be determined by experience. Dr. Larsen has place on record with the Commission a difference of opinion as to interpretation.

14/ National Health Act of 1946 (S.2143) - Introduced by Senators Taft, Smith and Ball, May 3, 1946.

CHAPTER III

CONCLUSIONS AND RECOMMENDATIONS

Out of the general and special studies, with much of the data and other material presented in Part II of the report, the Commission reached its conclusions and recommendations. These relate, primarily, to the subject of adequate financing and to the medical, social and administrative aspects of organized payment. In its recommendations the Commission recognizes that its chief task is to suggest adjustments of an existing system of service to the growing needs of the people. What the Commission recommends is the beginning of an orderly progress through organized payment toward the goal that all of the benefits of the medical sciences shall be available to all of the people of the Territory according to their needs.

A. ORGANIZED PAYMENT

The organization of payment for medical care is based upon the concept of mutual aid. Throughout the history of medicine and hospitalization this concept has occupied a prominent position. The hospital is a striking example of the manner in which a group or an entire community engages in a joint effort to provide a necessary medical facility. Physicians, too, support the concept as one of the fine traditions of their practice when they attempt to apply the principle of a sliding scale of fees.

The tradition of high fees for the rich and low fees or no fees for the poor is a recognition by the medical profession of one of the guiding principles previously expressed by the Commission. It is the principle of payment according to economic ability and service according to medical need. It is probably true that in a simple system of medicine practiced in a simple economic system the theory of the sliding scale of fees to meet the needs of the people was applicable. But now neither system is simple. In order to make the sliding scale work each physician would need to include in his practice a cross section of the population, from rich to poor. And the rich would need to provide enough patients to counterbalance the costs of those who are poor. Neither of these things happen. It is only by a system of payment on an organized basis, whereby a large group of people share the risk of unpredictable illness and its costs, that the problem can be met in a forthright fashion.

Organized payment raises an immediate question. The word "compulsion" is displeasing to the American mind and anything to which it is attached arouses resistance. It implies the use of force to make people do something that they dislike. But the vigorous debate apparently gives little consideration to changes that have taken place in recent years in existing medical and hospital plans.

In arriving at its decision on this subject the Commission reviewed the trends in the development of organized payment in the United States. Over ten years ago when hospital insurance was inaugurated the line between compulsion and volition was drawn rather sharply. What compulsory features existed were submerged in the various pressures of "good salesmanship." In what was regarded as a direct transaction between employees and a hospital plan, the employer was excluded except as an agent to collect the funds through payroll deduction. That period has ended and today employers are urged by the plans, both hospital and medical, to contribute all or a part of the costs for their employees. Furthermore, there is a growing tendency to include medical and hospital services among the provisions of collective bargaining contracts between employers and employees. Thus, the once sharp dividing line is being erased in a significant fashion. Whatever may have been the theories regarding compulsion they are being displaced by a more solid and tenable concept. This is the concept of organized payment as a means of dignified self-support, as a device whereby the principle of mutual aid may be applied. The Commission is impressed by the increasing emphasis that is being placed upon the <u>obligation</u> of people to accept the responsibility of mutual aid and participate in a system of organized payment.

The Commission deplores the too prevalent tendency to use organized payment for medical care as a football -- at one period in the possession of the medical profession and the hospitals, at

another held by industry and at another in the possession of labor. Organized payment involves the welfare of the people and should be regarded as the privilege of the people. To use it as a pawn is to decrease its essential values.

The Commission, therefore, recommends that the people of the Territory, by formal legislative enactment, accept the obligation to participate in a system of organized payment for medical care.

This is the Commission's first recommendation to the Twenty-fourth Legislature. The succeeding recommendations are predicated upon this one. They will deal with the services that should be included, the population that should receive the benefits, the details of organization and administration, the costs and other matters. But the key to an orderly progress toward the full values of medical care lies in the majority acceptance of the obligation, as expressed.

The social and economic stability of organized payment must be assured if the system is to operate successfully. The best "medical risks" in a population are the single employed individuals in the younger age groups. The principles of mutual aid and payment according to ability place upon such individuals the social responsibility to participate. Otherwise the family is penalized.

Economic stability means that there must be a continuity of services in relation to need. It is one of the tragedies of the existing system of medical care that it is so susceptible to temporary economic disruptions. While any long-continued depression affects the whole economic structure of the nation, the Commission visualizes a system of organized payment as a stabilizing influence as far as medical services are concerned. The methods of assuring this stability are discussed in connection with other recommendations.

B. THE MEDICAL BENEFITS

The Commission's decision concerning the immediate medical benefits that should be included in the system of organized payment is based upon a number of considerations. The ultimate objective, that of adequate services for all of the people, has been stated. But between the present and the future there are a number of steps and there must be a reasonable assurance that each one will place the weight of progress on a firm foundation.

The Commission recommends that the initial benefits include hospital care and the services of physicians to hospitalized patients. 15/

The above benefits meet the expressed criteria of medical soundness, i.e., that the services provided should constitute a substantial attack on the problem of medical care. It is within the walls of the hospital that approximately fifty percent of the costs of medical care are experienced. And while there are other economic burdens of illness it is in the hospital that they tend to concentrate. Therefore, to include the recommended benefits is a long step forward.

1. Hospital care. By hospital care the Commission means those services and facilities for in-patients that are usually provided in general and related hospitals. In the latter group are certain hospitals such as those that provide services for maternity care and for children. Primarily the general and related hospitals are organized for the treatment of acute rather than long-continued or chronic illness. Hospital authorities deplore the fact that many beds are being utilized for chronic bed-ridden patients who could and should receive care in other types of institutions such as nursing homes. Data from hospitals in Hawaii show that about 200 beds, almost ten percent of the total, in general and related hospitals are being used daily for this class of patients because there is a lack of other facilities for their care.

The Commission recognizes and would direct the attention of the Legislature and the people to the growing problem of chronic illness. This type of illness occurs among all age groups but it is most prevalent among the older ages. Inevitably it must be faced. As the span of life increases and the population stabilizes it is expected that about twenty percent of the people will be in the age group above 60 years. In 1940 there were approximately 23,000 16/ people in this group in the Territory and it is estimated, conservatively, that in another twenty-five years the number may rise to above 15 percent of the total population. Because a large percentage will be receiving the benefits of old age annuities they will be regarded as self-supporting. Yet

15/ Exclusive of patients hospitalized under the provisions of Workmen's Compensation legislation and certain other groups that receive care through Federal Funds.

16/ Estimate based on data from 1940 Census

their annuities begin at a time when the occurrence of illness reaches a peak. With illness and its expected costs at high points it is hopeless to think of any reasonable annuity as providing full self-support. Obviously an annuity system must be buttressed by a system of medical service and organized payment. Whether such a system will develop on a national basis or be accepted as a state responsibility, comparable to what has taken place in the state of Washington, remains to be seen. However, the nature of the problem, the existing facilities, the need of more facilities and the probable costs are subjects that should engage the attention of the people of the Territory. Visualizing a problem that will become more and more pressing, it is a course of wisdom to prepare to meet it.

Keeping in mind the primary purpose of general and allied special hospitals the immediate question before the Commission was the degree to which any specified number of days of hospital care might meet the needs of the greatest number of people. The existing data are in agreement that over ninety percent of all patients admitted to general and related hospitals are discharged within a thirty day period. Therefore the basic recommendation of the Commission is that the organized system of payment should provide hospital care for each distinct illness up to a period of thirty days.

At the same time the Commission recognizes that a certain percentage of cases warrant care for periods beyond thirty days. Aside from what has been said about the need of facilities for chronic bed-ridden cases, there is another group of patients that presents the problem of protracted acute illnesses. Primarily the problem is one of meeting the costs and, therefore, will be considered further in the sections devoted to this subject.

Stated more specifically, the recommended services in the general and related hospitals include the following:

a. Ward Bed and Board
b. General Nursing
c. Operating and Delivery Rooms
d. Anaesthesia
e. X-Ray, Laboratory, Physiotherapy Facilities
f. Drugs, Dressings and Casts

The primary purpose of the included hospital care is to meet the medical requirements of the patient; barriers to service should be only those that are compatible with good administration. In a number of proposals and plans reviewed by the Commission rigid limitations have been imposed upon certain of the above services, such as x-ray and laboratory. The limitations are defended as in the interest of financial solvency and because there is a lack of reasonably adequate knowledge concerning the real needs. In recommending that no limitations be placed on the included hospital services, the Commission by no means minimizes the importance of solvency. No system of organized payment can be medically or socially sound unless it is economically sound. But there are other ways to protect solvency and these will be discussed when the subjects of Organization and Administration are considered.

2. Medical Services. The Commission defines the medical services as those rendered by qualified Doctors of Medicine to patients that have been admitted to general and related hospitals. Using broad categories of hospital patients, the services are those necessary to the care and treatment of medical, obstetrical and surgical patients. Such patients should be admitted to the hospitals on the recommendations of their physicians and should receive the necessary medical services during the period that has been specified for hospital care.

The Commission at this time recommends one exception to the rule of physicians' services for patients that are hospitalized, only. In the interests of preventive medicine and in accordance with the common practice, the system of organized payment should include antepartum and postpartum care for maternity cases.

What has been said about long-continued illnesses and the limitation on the days of hospital care would apply to the limitations on physicians' services. A strong case could be presented showing the need of diagnostic services for non-hospitalized patients, of physicians services in offices and homes, of dental care, home nursing and other services. The criticism may be made by general practitioners of medicine that the initial system of organized payment places undue stress upon and assigns undue importance to medical specialists' services in hospitals. To these statements or criticisms the Commission can make only one response. It recognizes the importance of curative and preventive medical services outside the hospitals and it recognizes, too, that the

costs of such services does become burdensome for many families.. Its response is to reiterate the previous statement and express the hope that ultimately all of the benefits of the medical sciences shall be available to all of the people according to their needs.

The position of the Commission in its selection of initial services is not one of dogmatic defense. The selection was based upon its study of the experience with the burdens of medical costs -- where they fall and how they fall upon an American population. Elsewhere in the world, many of the systems of organized payment have started with the services of general practitioners in homes and offices and during the course of years have expanded to include special medical services and hospital care. It is not improbable that if a Territorial Commission had been appointed fifty or thirty years ago its recommendations would have followed the same pattern.

The foreign experience of the past or for that matter, of the present time cannot be utilized directly to fit the American form of medical care. This statement has no relation to political philosophies; it does have much to do with the growth of special medical services and with the enormous increase in hospital facilities. The population's choice of services has become an American tradition; what better evidence is necessary than the fact that 92 percent of all the births in the Territory took place in hospitals. It is the hospital that is assuming an increasingly important role as a center of medical care; it is in the hospital that physicians' services are concentrated; it is in connection with illnesses that are treated in the hospital that an American population experiences its greatest burden of costs. These were the impelling reasons that determined the Commission's choice of initial services.

To provide for less services would result in a program that would fall short of meeting the most pressing medical needs; to include more at this time would multiply administrative complexities. Though the complexities might be resolved little would be gained in the long run if, at the outset, frictions that might develop left their lasting marks. What the Commission visualizes is an organized system of payment operating with a minimum of defects from the day that the physicians and hospitals begin to provide services.

The limitations themselves emphasize the fact that progress toward expanded services should involve a series of steps. This is the first one and, looking to the future, continued study must be assured. Toward this end the representative body (described in the section on "Organization and Administration") charged with the duties of adopting policies governing the system of organized payment should also be charged with the responsibility to continue the studies initiated by the Commission. The responsibility should be defined and the representative body should be required to report to future Legislatures, giving the results of their study and making recommendations regarding additional services.

The recommendations that have been made will excite many questions -- from physicians, from hospitals, from the public. Like all general recommendations they do not provide a sufficiently tangible framework within which each physician can see himself, his patients, his services, his economic and other interests. And the same intangibility applies to the hospital and the public. The Commission has no intention of adhering to any refuge of broad and vague generalities. Its objective, in the recommendations that follow, is to stress the details of the system of organized payment.

C. THE INCLUDED POPULATION

The ultimate goal of the system of organized payment has been expressed and in the preceding section the limits of medical services when the system is inaugurated have been discussed. There are also certain limits that must be considered with respect to the included population resident in Hawaii.

Although the Commission will consider the financing of the services in a later section of the report, the subject has an important bearing on this section. There are a number of ways to finance services. The one that has the most widespread application is the system whereby the potential recipients of services pay all or a portion of the costs. And for the payments the contributors and their dependents receive the specified services.

The phrase "contributors and their dependents" calls for definition. In its limited sense a "family" might be defined to include only parents and children under a specified age, such as 19 years, living in the same household.

The Commission recommends that the definition be broadened to include other fully dependent members of a family living in the same household.

c Viewing medical care as a family problem it recognizes that an even more inclusive definition is, perhaps, indicated. There are many instances where a person may be the sole support or chief contributor to the support of a sister, brother, parent, grandparent, or other relation living outside his household. How many such cases there are and the extent to which their inclusion would increase the number of people entitled to services are questions for which there are no immediate answers. It is certain, however, that answers should be sought and, as early as possible, these types of dependents should be included. To exclude them at the start is a regretable decision that is made in the interest of economic and administrative soundness.

A second group, that does not lend itself to inclusion when the system is introduced, is made up of the various categories of the population for which public medical service is providing or should provide medical care. This is the group, divided into a number of categories, that is dependent upon public support; it is the group for which the Territory and voluntary agencies expend funds for a wide variety of medical services. At present the Public Health Committee of the Chamber of Commerce is completing a study of the organization and the costs of such services.

The chief reason for the exclusion lies in the Commission's recommendation for limited medical care. If the Commission had recommended comprehensive services there would be no justification for the exclusion of this group at the beginning. Having recommended the limitations, it would be administratively inadvisable to include people who must have comprehensive care. Having little or no means of their own their medical care must include home and office or clinic services by physicians as well as services from other medical personnel. For the system of prepayment to provide such services would call for a dual system of administration, with limited services for some and comprehensive services for others.

While the Commission recommends the exclusion of those receiving public support there is one important mitigating factor. In any population there are individuals and families that are self-supporting even though their incomes are comparatively low. When illness strikes they have little recourse other than the free care of physicians and hospitals or public medical services. For that reason they are classified as "medically indigent," in the sense that their medical needs force them into indigency.

A system of organized payment, based upon the principle of mutual aid, should reduce the number of those classified as medically indigent. By whatever method they may contribute to a system of organized payment or by whatever amount of money that is within their means, they should be entitled to services when the need arises. Thus, they would not become medical indigents.

Summarizing the foregoing, the Commission recommends that, with the exception of the groups receiving public support and, therefore, eligible for public medical service, and within the limits of administrative feasibility, the population of the Territory be included in a system of organized payment.

The question of administrative feasibility is raised with respect to Federal employees and veterans. Federal employees present a particular problem that will be considered in the discussion of methods of financing the system of organized payment. The problem of the veterans is a different one that needs some clarification.

The impression is prevalent that veterans are entitled to comprehensive medical care under regulations of the Veteran's Administration. The care may be given either in a hospital operated by the Federal government or, if none is readily available, by private physicians and non-Federal hospitals in veterans' home communities.

Actually, veterans are entitled to comprehensive care for service-connected illnesses or disabilities. If a Federal hospital maintains outpatient services the care of other illnesses may be included. If a veteran suffers from an illness that has no connection with his service in the armed forces he is permitted to enter a hospital (Federal) provided that a bed is available and he declares his inability to purchase the necessary care. These are the restrictions, no matter how broadly they may be interpreted.

The future might bring a relaxation of the rules. But at this time the veteran is entitled only to a limited service for himself and none for his family. For these reasons there is little that would justify the exclusion of veterans and their families. Nor would it be justifiable, administratively or socially, to attempt any segregation whereby veterans might be excluded and

their families included.

The temporarily-limited definition of the family, the indigent group with its variable size, these combined would total an estimated three to five percent of the population. With few exceptions the scheme of organized payment would include the remainder or approximately 500,000 people.

The Territory, because of its existing system of taxation, is in a peculiarly favorable position to inaugurate a contributory scheme of payment. Likewise, its distinctive types of agriculture make it possible to include agricultural employees under conditions that are not duplicated in any of the states. It is estimated that, according to islands, the following numbers of people would receive, when necessary, the included services:

TABLE 8

County	Estimated Included Population
Honolulu	344,300
Maui	33,400
Hawaii	67,900
Kauai	52,000
Total	497,600

D. ORGANIZATION AND ADMINISTRATION

The recommended legislative action has as its purpose the pooling of adequate funds to be expended for the services described. But it is organization and the day-to-day administration that will determine the degree of success with which the purpose is carried out. Adequate administration calls for broad policies but broad policies, however praiseworthy they may be, do not apply themselves. They must serve as a solid foundation for administrative details because it is this type of detail that is seen by and affects -- favorably or unfavorably -- the physician, the hospital, or the patient. Unlike certain other services the success or failure of a process of medical administration is almost immediately discernible because it touches so many people so intimately.

As stated, the methods by which funds are accumulated are discussed in the section on "Cost and Financing." The primary attention in this section is upon the arrangements, including both organization and administration, for the distribution of the services. Certain details of administrative policies will be considered first.

1. Administration

a. Form of benefits. The benefits that are provided in a system of organized payment may be in the form of cash indemnity or services. Assume, for example, that a patient suffering from appendicitis enters the hospital and the surgeon performs an operation. The patient occupies a ward bed and remains in the hospital eight days. Under a cash indemnity system the patient would present the evidence that services had been received. Whereupon, the patient, if he had paid his hospital bill, or the hospital would receive a payment for eight days at a specified rate per day. The rate per day might cover the actual costs but they might cover only a part of the costs dependent upon what the hospital might charge for the bed, operating room, anaesthesia, drugs, dressing, laboratory and other services. For some of these services the patient might also be reimbursed; he might receive up to $15.00 or $25.00 for X-ray and the amount may be sufficient to pay the total of the X-ray item or only a part of it.

For the surgeon's service the same general procedure would be followed. The patient might be reimbursed or the payment of the allowed amount might be made to the surgeon. Dependent upon the surgeon's charges, the allowed amount might be enough to pay the full cost or only a part of the costs.

In a system of service benefits, as the name implies, the patient receives services rather than a cash indemnity. The administrative agency enters into an agreement with the hospital to provide services at specified rates which are paid by the agency. The rate might be higher in Hospital A than in Hospital B, but if the patient's contract calls for a ward bed and the patient occupies a ward bed in Hospital A he does not make any extra payment.

Likewise the administrative agency enters into an agreement with the surgeon. It is the agency that pays the bill and the patient may even be unaware of the amount.

Cash indemnities have one commendable feature; they are more simple to administer. The burden of obtaining the services is upon the patient; the terms of the contract apply to the patient and the administration; the administration has no problem of hospital relations; there is not even a need to engage the medical profession in any discussions of their charges. But, except for one deviation that will be discussed, the Commission recommends the service type of benefits.

One of the major reasons for a system of organized payment is the protection it offers against the unpredictable costs of illness. When the benefits are in the form of a cash indemnity the element of security is decreased. The reason is that not until he needs the service does the patient learn the extent of his protection. When the need arises, as in the above case of appendicitis, the patient may find that his protection covers only a part of what the surgeon may charge since there is no arrangement with the surgeon for a specified charge. It is to the great credit of the medical profession that, in the majority of the plans they have supported, the benefits take the form of services rather than cash indemnity. The choice of this type of benefit, however, carries with it the responsibility that the compensation to institutions and professional personnel must be reasonably adequate.

It was stated that the Commission recommends service benefits, with one deviation from or exception to this general rule. The exception arises from a realization of the position and outlook of the medical profession. As was shown, the sliding scale of fees does not solve the economic problem of medical care because it assumes that each physician serves an economic cross-section of the population and that there are enough wealthy patients in each physician's practice to compensate him for free or low-paid services to the lower income groups. Neither assumption is correct but there is another situation that is self-evident.

The tendency of the well-to-do families in a population to cluster about certain physicians is well known. The costs of physicians' services to these families are much above the average with the result that a relatively small number of physicians show unusually good incomes when compared with the main body of practitioners. It is quite understandable, and little is gained by any tendency to criticize, why physicians with a fairly large proportion of their practice among the well-to-do are cool toward any rate of payment that would obviously reduce their total income. As an example, the case of an obstetrician who delivers 300 babies per year may be used to express the situation more tangibly.

Assume merely for the purposes of this discussion that the average charge for an obstetrical case in the community has been $75.00. Some cases will receive care for $35, others $50, and the charge for others may be $300 or more. If it is suggested that the rate in an organized system of payment should be $100 it is simple arithmetic to prove that for all obstetrical care in the community the funds expended will be a third more than previously. But while the great majority of physicians might welcome the increase, the obstetrician with the 300 deliveries a year resists the proposal.

A review of his income according to the deliveries might show the following picture:

TABLE 9

Group	Total Cost
20 cases at $300	$ 6000
100 cases at 200	20000
100 cases at 150	15000
50 cases at 50	2500
30 cases at 00	----
Total	$43500

To ask the obstetrician to accept a fee of $100 for each of his cases is to ask him to accept a total income of $30,000 instead of $43,500. He might be willing to average the last three of the above groups of cases at $100; it is unlikely that he would be willing to include the other 120 cases at the same fee. And if there were no alternative he might elect to remain outside the scheme of organized payment even if it meant that many of his former patients in order to secure the benefits would choose other physicians.

The above figures are presented only as an example but the same principle would apply to other types of practice. And as far as the average physician is concerned, even though he may serve a well-to-do patient only rarely, the privilege of a higher fee has become traditional.

These were the realities that the Commission recognized in its consideration of the form of benefits. For the large majority of the population only the service benefit will provide the necessary protection; there is a minority, however, for which the indemnity benefit is the recommended form. This is the deviation that was mentioned previously.

The Commission has in mind a form of benefit that will eliminate any justifiable economic incentive for non-participation in the scheme of organized payment by any physician. To that end it suggests a line of demarcation at the $5000 level of annual family income. Below that line the service benefits would prevail; above it the system would contribute specified sums for specified services rendered by physicians. Thus, for that group in the income bracket above $5000, physicians would be permitted to maintain the traditional economic relationship. At the same time, the benefits for this group, though in the form of an indemnity, would be equal to those of families in the lower income brackets. As an example, take the case previously mentioned where the delivery fee is $100. For the service to any family in the lower brackets the physician would receive this amount as full payment. For the service to any family in the higher bracket the same amount, $100, would be paid either to the physician or the family. It would be applied to whatever fee the physician and the family have agreed upon.

The line of demarcation at the $5000 level of income provides a fair division, both for families and physicians. To draw the line lower than this would place too many families in a vulnerable position with respect to their protection. This was recognized when the Hawaii Medical Service Association was organized and the same principle is recognized in the majority of physician-sponsored medical plans. Recently, such a plan was announced by the organized profession of Washington, D.C. In that area families with incomes below $4500 are to receive service benefits. It is true that an income division adds to the problems of administration but it is also true that the gains of simplification may be far outweighed by the friction in a system where no division prevails.

How many families and individuals in the Territory might be found in the annual income classifications above and below $5000? According to the data collected as a part of the Commission's studies those whose incomes are from wages and salaries show the following groupings:

TABLE 10

TERRITORY OF HAWAII
INCOME BRACKETS

Income Bracket	(a) Comp. and Dividends		(b) Net Income	
	Number of Returns	Percent	Number of Returns	Percent
Under $2,000	201,600	72.0%	128,393)	78.2)
2000 - 3,000	42,000	15.0	)	)
3000 - 4,000	19,600	7.0	21,301	12.9
4000 - 5,000	11,200	4.0	8,558	5.3
Above 5,000	5,000	2.0	6,033	3.6

(a) 1943 percentages applied to 1945-46 tax base and collections.
(b) From federal income tax returns, 1942

While the above group with an annual income less than $2000 would be expected to include many part time or seasonal workers, it is obvious that in the practice of the average physician the combined groups with incomes of $2000 to $5000 from salaries and wages occupy an extremely important place. It is estimated that the above income groups, including the family members, embrace at least 400,000 or 80 percent of the total population.

The remaining self-supporting population includes those who are self-employed and those who, though not employed, derive their livelihoods from other sources of income. While the data regarding income classifications for this group are inadequate it is estimated that when the number above a $5000 income are added to the number receiving salaries above $5000, approximately eight percent of the total of all income groups would be included: Thus, it is estimated that the division of $5000 would place about 92 percent of the families below and 8 percent above this amount.

The line of demarcation recommended by the Commission will be criticized by extremists who desire a complete change in the system of medical care and by extremists who want no change. Compromise has been described as "a crazy quilt in which everyone can identify his patch; he can find consolation in his disappointment by reflecting that everyone else is disappointed too". 17/ The Commission does not hold with this view that is too prevalent and too sour. The compromise suggested, rather than one where everybody loses, is like all reasonable compromises wherein the good of the many -- physicians and patients -- prevails over the inflexibility of the few. And it should be emphasized again that payment for services must be reasonably adequate.

In summary, then, the Commission recommends that services shall be the prevailing form of the included benefits, with the exception that for the population with annual incomes above $5000 the benefits shall take the form of an indemnification.

b. Free Choice of Service. The right or privilege of the patient to choose his physician and the right or privilege of the physician to accept the patient are subjects that have excited endless discussion. It is true that choice under present conditions is limited by a number of factors -- geographic, economic, social, and others. It is also true that few patients have sufficient knowledge to justify the choice of a physician on a scientific basis. And, finally, it is true that medical services of high quality are available in teaching institutions, certain clinics and elsewhere with the patient having little choice in the selection of any particular physician.

Much has also been written on the organization of medical services to provide more effective care through the development of group or coordinated medical practice. Whatever may be the future growth of this type of practice the Commission must deal with the problem previously described -- a more satisfactory distribution of the services with the personnel and the facilities organized as they are now.

Reviewing the numerous polls of public opinion, the privilege of free choice, from the public's standpoint, is given high value. Psychologically, the right to choose a physician and the confidence in him are related. In any system of organized payment one of the chief interests should be the continued improvement of the physician's knowledge so that the whole community may benefit.

The Commission recommends that in the system of organized payment the principle of free choice be maintained. It is recognized that certain limiting factors that exist now will continue to exist. For example, the choice of a hospital in many cases depends upon the staff privileges of a particular physician; in plantation practice there are geographic and other limitations. But for the largest percentage of the population the principle will offer a wider latitude of free choice than now exists.

c. Payment for Services. Payment for services is one of the crucial points upon which there hinges much of the favorable or unfavorable reaction of physicians and hospitals to a system of organized payment. The subject involves not only the amount of payment but also the form or method.

(1) Payment to Physicians. In various systems of organized payment physicians are compensated for their services by one or a combination of the following methods:

17/ Laswell, Harold D., "Social Conflict", Encyclopedia of the Social Sciences, 4:194-196

(a) Fees-for-services
(b) Capitation payments
(c) Salary payments

The fee-for-service is the method that is common in American private practice and in the majority of the plans operating in the United States. By agreement with the medical profession fees for specified services are established and the physicians are paid accordingly.

The capitation or per capita payment is a method -- its use typifies the system of payment that developed in England -- whereby a physician or a group of physicians may be compensated at a flat rate per person per year. For the services of the general practitioners each potential recipient of care in an included population chooses his physician. According to the number of people on his list the physician receives a per capita payment regardless of how much or how little service he renders.

In a system where payment is by salary the physicians are compensated on a basis of full-time or part-time. Other variations are payment on an hourly basis or at a specified rate per session in a clinic.

Generally speaking the physicians of the country by their statements and actions have indicated that they prefer the fee-for-service payment. This may be due to the fact that the method is the one with which they are most familiar. There is little question, however, that the method, if it is to be used with success, calls for administrative ingenuity plus the positive support and cooperation of the profession. As has been demonstrated too many times to refute, a careless minority among the profession may work untold harm to the system of payment and, therefore, to the great majority of their colleagues in practice. In short, the fee-for-service method of compensation will not work merely because there is a unanimous vote in its favor; to make it work calls for a combination of administrative judgment and balance plus professional support and participation in any controls that may be indicated.

Situations might develop that would call for the application of other forms of payment but with respect to the proposed services the Commission recommends the fee-for-services as the primary form of payment to physicians.

As stated, not only the form but the amount of payment is of interest to physicians. And the amount of payment is also one of the keen interests of the public. With fee-for-service as the primary form of payment it is necessary to adopt a fee-schedule by agreement between the medical profession and the administration. This should offer little difficulty since the general pattern of fees for specified services, especially for those with annual incomes below $5000, is fairly well established. But, as a preliminary to the later consideration of costs,it should be said now that lower total costs should not be anticipated as a result of organized payment. One of the values of organized payment lies in the provision of services according to needs. Hence, more services will be rendered to the total included population when there is no longer an economic incentive to resist or indefinitely postpone needed care.

There is one other problem of payment that can be resolved only by the joint action of the administration and the medical profession. The problem has to do with the payment of those physicians who are especially qualified in a given field of medical care. Should such physicians receive a higher fee than those who are not as well qualified? If so what should be the difference for a specified service? If a higher fee should be paid it would be necessary to adopt standards of qualification. Whether the standards should be licensure by an American specialty board or a new set of standards would be within the prerogative of the medical profession to decide. As far as organized payment is concerned the chief interest in the subject is the quality of medical care.

(2) Payment to Hospitals. A significant transition is taking place in the concept of hospital operation. More and more is it being recognized that the hospital is not only a medical institution; it is a business institution that cannot function successfully if its economic position is precarious or unstable. Above all, the hospital is a community institution through which vital services are maintained for the people. To speak of "helping the hospital" as though that were an end in itself is to confuse the purpose of hospitals. It is hoped that endowments and bequests intended to expand and improve hospital services will always be a mark of American sympathy and human understanding; to depend upon endowments and bequests for any appreciable portion of day-to-day and week-to-week services is to shorten the lives of hospital administrators.

Hospitals in their very nature are public or semi-public utilities regardless of their ownership. It is expected that they be operated economically and that their rates be adequate to meet costs. Obviously the costs will vary from institution to institution. Some are large, others are small; some have a high percentage of their beds occupied almost all of the time, others a lower percentage; there are differences in construction, differences in services and other variations that are reflected in the costs.

The purpose of organized payment is to meet the needs of patients at rates that permit hospitals to continue the provision of their services to such patients. This places upon each hospital the responsibility of a satisfactory cost analysis -- a phase of hospital administration that has been urged for years by the American Hospital Association. More and more hospitals are adopting standardized accounting since three government agencies -- the Children's Bureau, the Office of Vocational Rehabilitation, and the Veterans' Administration -- have started payment to hospitals based on a formula of costs.

The details of the formula used, with the changes recently recommended by the American Hospital Association, are presented in Part II. Its use establishes a per diem rate for a ward bed and all other services the hospital maintains. The rate is the average for all patients and its use greatly simplifies administration. The chief problem of the hospital is to establish a justifiable rate based upon known costs.

Since the medical need of the patient is the governing factor in a system of organized payment, facilities and services beyond this need should be excluded from any formula of payment. The patient would be expected to pay the difference in costs between that of a ward bed and a bed in a semi-private or private room. Whether the fact that he occupies a semi-private or private room should increase the costs of other services is a matter that calls for consideration. There is little doubt that organized payment that includes only a ward bed increases the demand for semi-private and private quarters. As a matter of fact, hospital authorities are questioning the advisability of providing wards in new hospital construction.

d. Administrative Controls. To the average physician administrative control seems to imply that his practice will be dominated by rules and regulations that do nothing except interfere with his services. It is not unusual for the physician to express this opinion and in some cases it is carried to such lengths that organized payment is coupled with varieties of feared political philosophies. When pressed for tangible evidence it develops that what the physician usually means is that he is opposed to maladministration -- a sentiment deserving of unanimous approval.

Whatever administrative controls may be adopted, they have one of two purposes. They are intended to improve the quality of services or to maintain solvency. As a rule any control to improve quality receives medical approval if it has even a partial chance of success. It is the rule to protect solvency that meets the greatest resistance and in many cases the resistance is justifiable.

Solvency may be endangered in a number of ways. The estimates of needs may have been too low and any rule that places the burden of the error upon physicians and hospitals or patients is unfair. Such a rule would provide, for example, that if funds are not sufficient to compensate physicians and hospitals in full the payments would be prorated according to the funds that are available. Or, as another device, patients would be charged by physicians and hospitals for certain services.

It is possible, too, that the estimates of needs and services are sound for a period of years. But during the first year or two the unknown "backlog" of need expresses itself. The evidence might show that the excess over the expected costs is wholly attributable to postponed needs. But no matter how clear the evidence it adds no funds to the treasury. And again the bills must either be prorated, payment withheld until some future date or charges be made directly to patients.

It is the control intended to prevent another possible cause of insolvency that causes the greatest irritation. Among any group of people -- physicians or laymen -- there will be a few who for one reason or another fail to abide by the rules that are accepted by the majority. And for the good of the group some type of curb must be applied. The need of curbs is recognized as important to any plan of organized payment whether it is operated by the medical society or another agency. If no curb is used or if it exists only on paper the chances are that the costs are high enough to absorb the punishment of inattentive or timid administration. Under these conditions the public loses and the great majority of the profession loses. The price is a high one for maintaining the fiction that no curbs are necessary.

It is the type of control rather than the need of control that arouses resistance. Any analysis of the cause usually produces one significant finding; not nearly enough attention has been paid to it. Briefly, the finding is that although a control is intended to curb the few its weight falls on everyone in the group. And the weight is resented by those who do not need control; in the case of physicians, those whose only interests are the best treatment of the patient according to his condition.

Certain examples will clarify what has been described as the significant finding. In one state where there is a medical program each bill submitted by a physician must be signed by the patient as evidence that the patient has received the service. For the few physicians who merit control procedures this is no obstacle; for the many it is interpreted as an attack upon their integrity. In another state the general auditing rules call for the notarizing of each bill -- an absurd procedure that has been protested by the medical administrator. In other instances limitations upon services, intended to protect funds, are irksome to physicians and patients alike. The refusal to treat a "pre-existing" illness or condition, the requirement of waiting periods before many of the services may be obtained, the rule that for a number of specified services there are added charges to the patient -- these and other devices, if they work at all, produce a semblance of solvency but, at the same time, give people the impression that they are being pushed around and are being told what they must or shall not do. The atmosphere is not conducive to success; it is the atmosphere of unsatisfactory administration.

The most effective control is one where the great majority who need no control -- physicians, hospitals, patients -- will not even be aware that any control mechanism is functioning. As for those who need control, they should not be left in doubt. To formulate and apply adequate controls calls for administrative latitude.

(1) Administrative latitude. Administrative latitude and solvency are linked closely. An administration that must work within narrow financial boundaries is one that must be prepared to adopt and enforce emergency rules to protect solvency. For example, if the unknown backlog of postponed services is large and during the first two or three years the costs must be absorbed by an income intended to care for normal needs, the administration has only one alternative. It must adopt emergency measures to protect its funds. Yet, everyone will agree that there should be little delay in giving care to people who need it, without regard to whether the need is a new one or has existed for some years.

Narrow administrative latitude is the chief cause of irritating controls. When an administrator faces the problems of making ends meet, virtually on a monthly basis, he must visualize all of the possible dangers to solvency and attempt to prevent them. He has little time to analyze experience and each upward trend in cost calls for some action. The fact that the upward trend may be due to a transitory condition is of little comfort; he fears that it may not be.

For the effects upon sound administrative latitude, for the influence upon sound administrative controls and for other values, as well, the Commission recommends as follows:

(a) That the legislative enactment take effect on July 1, 1947

(b) That the collection of funds begin on July 1, 1947

(c) That the distribution of medical and hospital services begin July 1, 1948.

Thus, one year will elapse between the adoption of legislation and the date when the services begin. And during this period a fund equivalent to the expense for one year will have accumulated.

It is the accumulated fund that will assure the necessary economic safety against the backlog of postponed services. And it is this fund that will provide the latitude that is so vital to successful administration. Such a fund virtually removes the usual irritating administrative controls. This does not mean that controls become unnecessary; it does mean that time can be used to determine when and where controls will be most effective.

For the included population the accumulated fund should provide added security. The security should be in the form of an assurance of the included services during periods of unemployment. The assurance means a continuity of services.

With the above protection against a possible deluge of unexpected though justifiable demand, the Commission can see only one danger against which, at the start, there should be some adminis-

trative control. Since hospitalization and medical care are provided for all types of cases there might be an incentive to over-hospitalize.

While there would be little cause for concern about obstetrical and surgical patients there might be an unwarranted increase of the cases classified as "medical". It is true that many patients need the diagnostic facilities available in hospitals; it is also true that the hospital may be an ideal place for many patients with common minor ailments. But as was stated with respect to chronic illnesses, there is danger that over-hospitalization for these types of patients would result in an unwarranted economic drain on the system of organized payment and, in certain hospitals, create a shortage of beds for other types of patients.

It is to prevent these possible results that the Commission can see no satisfactory alternative to its recommendation that non-surgical and non-obstetrical patients be required to pay the initial portion, up to a maximum of five days, of a period of hospital care. The Commission recognizes that for some patients in this group the burden will be a major one. If and when administrative experience justifies the step the burden may be lightened or removed. Meanwhile, the great majority of hospital patients, those classified as obstetrical and surgical and numbering three-fourths of the total, will receive the included hospital and medical services without additional payment.

There has been a previous reference to the need of certain types of patients for hospital and medical care beyond a period of thirty days. Coupled with the previous recommendation there is the further recommendation that a special fund be utilized to provide additional hospital and medical care for those patients with protracted acute cases of illness who require hospitalization for periods longer than thirty days. The administration should be given the power to designate the types of cases and the limits of the extended hospital and medical care. The estimated amount of the special fund will be presented in the section on "Costs and Financing".

The above control is the only one that should be applied when the services begin. With this exception the physician may render and the patient may receive the benefits of organized payment. The only fundamental change is that the physician, instead of billing the patient who is in the less-than-$5000 income group, sends his bill to the administrative agency.

e. Paper Work. The subject of paperwork -- the hated "red tape" -- also deserves comment. Much needs to be done to simplify the process of reporting services by physicians and hospitals. An acceptable per diem payment to a hospital goes far in the direction of simplification. And if a policy is adopted that stresses the fact that reports are for administrative purposes, not for hospital or medical research, many of the minute details in the average report may be eliminated. In effect the report to the system of organized payment replaces the bill that, under present conditions, is prepared by the hospital or physician for the patient.

As a step to assure immediate and adequate reporting each hospital might designate one member of its personnel to carry the responsibility. And the compensation for the added duty should come from the administrative agency and be absorbed as an administrative cost. Since the physicians' services would be rendered in the hospital the physicians should be given the privilege of having the designated member of the hospital clerical or record-keeping staff forward the medical as well as the hospital report. Furthermore any prohibitive, general auditing rules that exist should be revised to permit the use of a single copy of a simplified report form. Any duplication that may be necessary can be prepared through the use of duplicating devices in the office or offices of the system.

A comparable simplification for the patient is also stressed. Too often there is a delay in admission to a hospital because the hospital is uncertain whether the patient is in the system of organized payment. Based upon the accumulated fund, previously recommended, a card should be issued to individuals and families that would serve as the evidence necessary. The only question might be one of identity but in this matter the physician, upon whose request a patient is hospitalized, would be expected to provide reasonable protection to himself, the hospital, and the funds.

The above discussion presents only some of the aspects of administration. There are many other details to be discussed with those who provide services and by that activity participate in administration. Above all, flexibility of administration must be assured if there is to be an adjustment to new knowledge and new situations. Therefore, those who bear the responsibility of formulating the policies governing the system of organized payment should also have the authority to adopt and change the rules and regulations that guide the application of administrative details.

f. The Period of Preparation. In industry there are many references to what is called the "get-ready" period -- the period of intensive work that precedes any change. A "get-ready" period is as important to the successful introduction of a system of organized payment for medical care as it is to the use of a new mechanism in agriculture or to the manufacture of a new automobile. In these instances "get-ready" is accepted as a matter of fact but in organized payment it is a rarity.

The effective dates suggested by the Commission allow a "get-ready" period of approximately a year. It should be the most intensive period in the whole experience of the system. The months between July 1, 1947 and July 1, 1948 allow time to prepare the plans for the collection of funds and to begin laying a solid foundation of administration. This is the time for careful evaluation and selection of the key members of the administrative staff; it is the time to begin the deliberative conferences so necessary to a successful program of services.

The major activities during the period of preparation may be summarized as follows:

1. The development of the structure of organization (discussed in the next section)

2. The selection of the administrative staff.

3. The adoption of rules and regulations governing the details of administration.

4. The analyses of past hospital and medical experience as a basis of evaluating future changes.

5. An intensive educational program with respect to the purposes and functions of organized payment, the methods of obtaining services, the methods of reporting and the roles of physicians, hospitals, and the public in a more adequate system of services.

6. The determination concerning the individuals and families who are to receive services.

7. The determinations concerning the physicians and hospitals as the sources of services.

Each of the activities will take time; all must be integrated for their full values in giving the system of organized payment a fair start.

2. Organization. In recent years a number of insurance companies have included among their offerings to the public a wide variety of partial protections against medical and hospital bills. Between the companies the competition for business has been very keen. However, the Commission views organized payment for medical care as a public utility rather than as a competitive enterprise. As such a utility competition is not in the interest of the public good.

The collection of funds for a system of organized payment must be accepted as a responsibility of the Territory. This conclusion is based upon a principle already expressed -- the principle that payment to the fund should be in accordance with economic ability. In order to apply this principle it is necessary to utilize the mechanisms of government not only for employed groups of people but for the many who are self employed and others who are self supporting from incomes other than employment. It is estimated that with their dependents the latter groups would number approximately 100,000 people.

Two alternatives for the expenditures of the collected funds were considered by the Commission. One was for the government to enter into a contract with an existing or a new non-profit private agency. The complexities of such an arrangement are impressive since it would entail much more than turning over a large amount of money for stated services. For the protection of those who receive and those who provide services the government would need continuing assurance that the administrative principles described would be applied in a satisfactory manner. It would also need assurance that the type of organization, described later, would function in the interests of all who are concerned with a system of organized payment.

There are certain precedents for the above contractual relationship. They are to be found among a few voluntary hospital and medical plans that have contracted with governmental bodies to provide services to certain relatively low-income groups or relief groups. A more extensive arrangement for payment on a cost or cost-plus basis is seen in the contracts between the Veterans' Administration and the physicians and hospitals in a number of states and in the Territory for

the "home town" care of veterans. As a rule it is a non-profit medical or hospital plan that, as a fiscal agent, represents the interests of the physicians and the hospitals.

The Commission takes the position that a more forthright approach to the problem calls for the creation and organization of an agency of government, an agency that represents and is responsible to all those who have a stake in a sound system of organized payment -- the medical profession, the hospitals, employers, employees, the general public.

a. General structure. The function of organization is to assure, by systematic arrangements, that the objectives of the system of organized payment will be attained. In presenting its views on organization the Commission starts at the base of the pyramid rather than the peak; it begins with the local area rather than the Territory as a whole.

Organization in the local area is intended to develop and maintain the closest contact between the administration, those who provide and those who receive services. In each local area there are physicians, hospitals, employers and employees. Each of these groups should appoint a special committee on medical care, the number of committee members being determined within each group. Thus, as a rule, each local area would have four committees. The chairmen of the four local committees should select a fifth member as a representative of the general community. Thus, there would be a small group of five people who would serve as the members of an official local advisory committee to the system of organized payment. It is this committee that would advise the local administrative office; it is through this committee that a two-way flow of information would be maintained. The importance of clear and direct lines of communication cannot be over-emphasized.

In this portrayal of the organization of local advisory committees the Commission stresses the principle of equal representation from the groups that have been named. Any attempt to arrive at some type of arbitrary proportional representation is to invite struggles for domination and power. That type of struggle assures a certainty that the value of the committee will be negligible. In a committee that has equal representation it is very unlikely that on medical matters the opinion of the physician-member would be taken lightly. And when the employee representative expresses his views on any dissatisfaction reported by recipients of service it will not be brushed aside. Nor will each member feel that he alone carries the full responsibility for decisions that affect his group. While he is a member of the local advisory committee he is, also, the chairman of a special committee appointed by his group.

While the local advisory committee would be expected to meet monthly with the local administrator the special committees on medical care, appointed by each of the groups, also have their place in the structure. Quarterly or, at least, semi-annually there should be a full meeting of all the special committees and the administration to the end that problems may be defined, solutions considered and progress reported. Through these meetings plus a general educational program the people are informed and the administration remains alive.

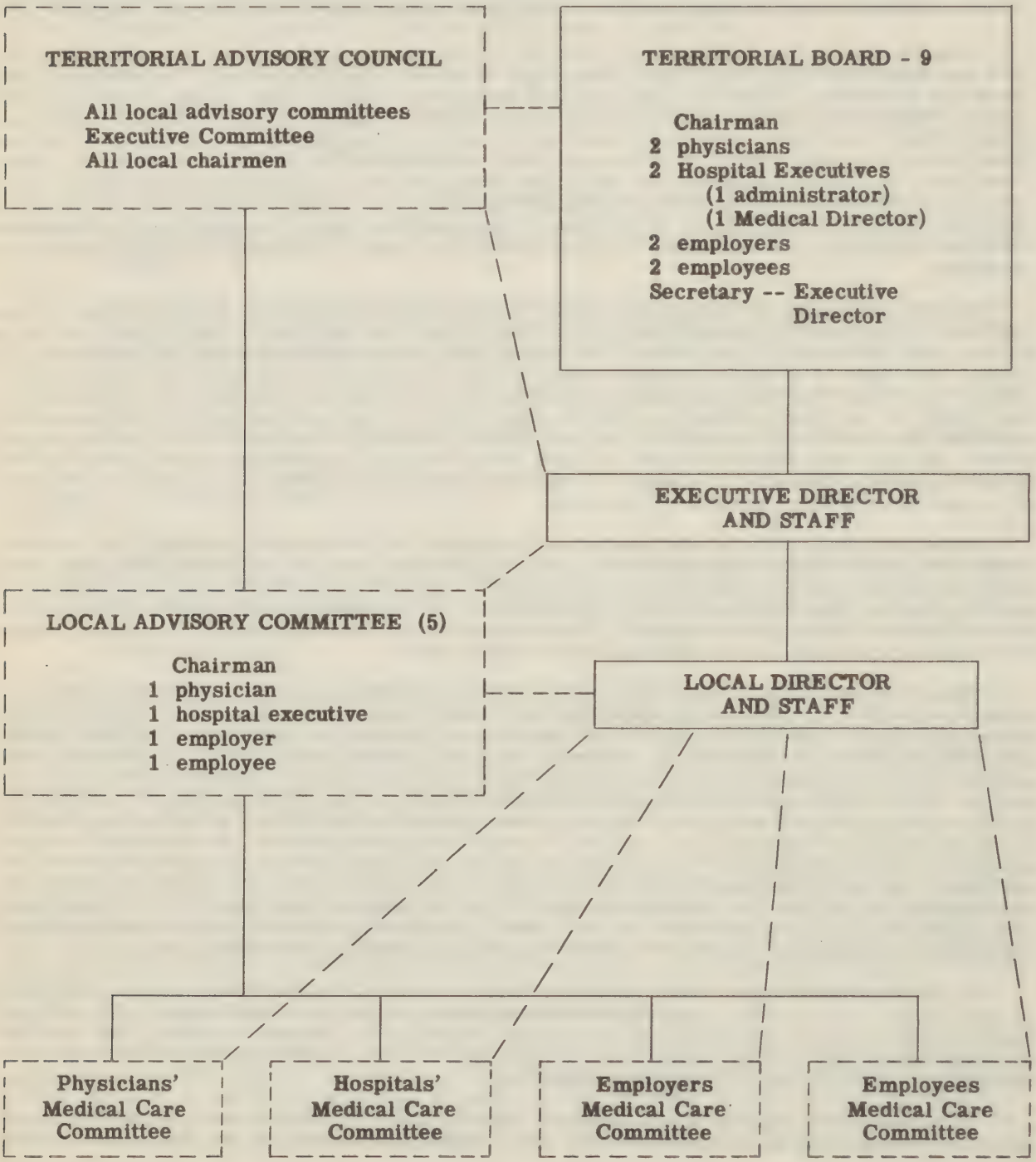
The principle of close relations in the local administrative area should extend to the Territory as a whole. A Territorial Board should be authorized to adopt general policies and rules and regulations to govern the operation of the system. As with the local area, the Board should be a representative one and, at the same time, of such a number as will permit reasonably speedy action. It is the Commission's view that a Board consisting of nine members is adequate. Two members should be selected from four names submitted by each of the following groups: physicians, hospitals, employers, and employees. The eight members thus selected should be given the authority to choose two names from among the residents of the Territory. Whichever of the residents is chosen would serve as the Chairman of the Board for a specified period of time. In order to conduct the business of the Board the Executive Director of the system should serve, ex-officio, as Secretary. And likewise to provide for continuity one of the two members first appointed from each group would serve for two years, the other for four years. Additional ex-officio members should include the executive officers of the Board of Health and the Department of Public Welfare.

To the Territorial Board there should be attached a Territorial Advisory Council consisting of the members of all of the local advisory committees. Annually or semi-annually the Advisory Council should meet with the Board; for any business that might be necessary between these meetings the Board should call upon an Executive Committee of the Advisory Council, such Executive Committee consisting of the Chairmen of each local committee.

The structure of organization as shown on the next page is a simple one. The membership, as described, would serve as an expression of their community interest and the total cost of main-

taining the structure would be only a minor charge against the costs of administration. The people -- the recipients of service -- would have a direct means of expressing themselves; those who provide service would have a like means. What has been said before cannot be over-emphasized -- the structure is intended to permit a free two-way flow of information and experience. When people have a real appreciation of each others' problems solutions can be worked out in an atmosphere of understanding and calm consideration.

ORGANIZATION CHART



b. Personnel. It must be accepted as a matter of course that no matter how sound the organization, no matter how logical the policies, the success of a system of organized payment will depend upon its wise administration. Successful administration calls for a detailed understanding of the problems of medical care, training for an administrative career and experience in the practice of administration. These are the qualities that should be stressed in the selection of the Executive Director and, though to a somewhat lesser degree, in the local administrators.

The principle of mutual benefit between the administrative personnel and the system of organized payment is vital to the success of the whole undertaking. Administrators who bring to the system the above qualities must be assured of a reasonable continuity of employment. This means the protection of such employees against political tempests or the unjustifiable demands of any vocal minority groups. It is unfortunate that the field of medical administration, now beginning to emerge as an important career, has received too little attention in the United States. As a result the choice of administrators is greatly limited. Educational and personal qualifications plus practical experience are the minimum elements that must be sought in the selection of administrators and standards should be adopted that will assure the best selections. And, again, the Commission emphasizes the importance of the "get-ready" period and its contribution to the solution of this problem.

c. Education. Education has been mentioned a number of times but in this section the reference is not to the general program but rather to education of a special type and as a part of organization.

There is nothing simple about the quality of medical care nor are there many precise measurements by which it may be judged. Quality is a complex combination of factors. Entering into the combination is the adequacy of facilities, what the physician and other personnel know and do, what the patient knows and does. When a patient suffering from cancer in an early stage postpones his visit to a physician until the case is hopeless, the physician is helpless. And if a physician, even though adequately trained and abreast of new developments finds the facilities inadequate the quality of care suffers. These points are mentioned because of the too-great tendency to discuss quality as though it were a simple matter and as though two communities, two states or two nations may be compared directly. In the present state of knowledge such comparisons are scientifically insupportable.

Despite what has been said a clear goal of any system of organized payment is the constant improvement of the quality of services available to the people in the area where the system operates. After the system is in operation three, five, ten years the crucial question will be, "Is the quality of care better in this area than it was when the system was introduced?" To answer the question objective measurements must be devised but if it is to be answered "Yes," attention must be given to quality from the day the system is introduced.

Whatever other medical personnel may contribute to medical care the service of the physician is the hub about which all services revolve. It was said that the stream of medical discovery shows no signs of a diminished volume. Therefore, the physician faces the responsibility of studying medicine from the time he enters medical school until he retires from practice. Nor can the study be sporadic and haphazard.

Continued medical education calls for a program, organization and financing. It is in this effort that the organized medical profession plays a key role, bringing the experience of past efforts and programs to the development of formal, organized and consistent means whereby all physicians and other professional personnel may have access to newer knowledge in medicine. The Commission visualizes a Territorial curriculum of postgraduate medicine paralleling the system of organized payment and financed from the administrative funds of the system. To the end that funds may be allotted and spent effectively a Committee on Postgraduate Education of the Territorial medical organization should be invited to submit, annually, a plan and a proposed budget to the Board. Furthermore, a specified percentage of the administrative funds should be set aside for professional postgraduate education. In addition to the medical profession other professional groups should derive the benefits of postgraduate training.

D. COSTS AND FINANCING

1. Costs. In presenting its estimates of the costs of the included services the Commission emphasizes certain of the fundamental features of the system of organized payment. The first feature is that, in large part, the estimated costs consist of money that the people will expend if no system of payment is adopted. In other words, without a system of or-

ganized payment the burdens of hospital and physician costs will fall only upon those people who need and must use the services. With organized payment the burdens are diffused; the costs are spread over the entire group as a protection to all against something that is unpredictable for any one person or any one family.

The second fundamental feature is that with the lowering of the economic barrier between the hospital and the physician and the patient, needed services that might otherwise be avoided or postponed will be sought. There will be a greater utilization of services and, therefore, the costs will be increased to a certain extent.

a. Hospital Costs. The estimates of the expected hospital costs are based upon data that were collected from the hospitals in the Territory. The information included the number of patients, the days of hospital care and the costs of services in the hospital.

During 1945 the general and related hospitals in the Territory served 60,186 patients who spent a total of 508,913 days in the institutions. The patients included all types - medical, surgical, obstetrical and all patients averaged 8.5 days in the hospital. Among those who occupied beds and are not included in the system of organized payment are the patients cared for under Workmen's Compensation, those for whom Federal funds provided care, the patients from families in the public welfare group and the chronic and other long-stay patients previously mentioned. It is estimated conservatively that the entire group that in 1945 would have been excluded from a basic system of organized payment would have comprised approximately 10,000 cases leaving a remainder of 50,000. And it is estimated further that if a limit of 30 days of hospital service had been maintained the number of hospital days would have been decreased to approximately 400,000 or an average of about 8 days per patient.

Looking toward the future it may be predicted that when the system of organized payment starts a rather abrupt increase in the number of hospitalized patients may be expected. If the figures for 1945 were used without any adjustment for an expected normal increase the calculation would be based upon about 100 hospital cases per 1000 population. Such an estimate for the first or second years of operation would, obviously, be too low. For these years the number might rise to 150 cases per 1000 population and it is because of this possible backlog of need that the accumulation of a one year fund prior to the beginning of service is so important.

For the longer range and in terms of what might be the normal year-to-year needs it is estimated that 110 cases per 1000 population will utilize an average of 10 days per case. Thus, the estimate for 500,000 persons expected to participate in the scheme of organized payment is 550,000 hospital days. This number would include certain special categories of patients who by reason of protracted acute illness would receive an estimated total of 50,000 days of service for periods longer than the limit of 30 days.

While the system of organized payment would provide an estimated 550,000 days of hospital care this number would not be the total load of the hospitals. Outside the system would be the patients - and the added hospital days -- from relief families, Workmen's Compensation cases, Federally-supported patients and others.

In 1945 the people of the Territory spent for the 508,913 hospital days a total of $4,917,483. According to the data from the hospitals the costs per patient day ranged from $8.00 to $10.83 according to the different islands. The over-all average for the Territory was $9.66 per patient day, since the greatest number of patients and days in the hospital were experienced on Oahu where the costs are the highest. This rate included all patients -- ward, semi-private and private.

While it is impossible to determine what future hospital costs will be the immediate estimate is based upon an average cost for all hospitals of $10.00 per patient-day. As already stated the payment to each hospital must be in accordance with its expense; otherwise the hospital cannot continue to serve the public.

The rate of $10 per day is the average for all patients regardless of whether they use ward beds or beds in semi-private or private rooms. Since the hospitals derive a higher income from the semi-private and private rooms and since the system of organized payment provides for services at the rate for a ward bed the calculation of total costs is based upon a rate of 90 percent of the average cost or $9 per day. Therefore, the expected 550,000 hospital days at an average of $9 per day would require a fund for hospital care amounting to $4,950,000.

b. Physicians' Costs. Using data obtained from the Territorial government it is estimated

that in 1945 the people of the Territory expended approximately $7,200,000 for the services of physicians in private practice. Included in the expenditure were the services of general practitioners and specialists rendered in the hospitals, in offices and homes. Included also were the fees received from those individuals and families in the upper income group as well as those with low incomes.

The Commission recognizes that the costs of physicians' services in the hospital will be determined by the fees that are charged for specified services -- obstetrical, surgical and other. However an approximation can be based upon a fair interpretation of the fee schedules that have been devised for the Hawaii Medical Service Association and the Veterans Administration. In addition, the expectancy of 110 cases per 1000 population or 55,000 cases from approximately 500,000 people is used as a basis. As with the hospitals, the 55,000 cases are exclusive of those already mentioned -- Workmen's Compensation, Federal, etc. And the estimate also excludes those added expenditures that would be made by those patients in the group having annual incomes above $5,000.

Using the above bases, a reasonably liberal estimate of the cost of physicians' services is $4,800,000. The estimate takes into account the fact that there will be a normally greater use of the physicians' services in hospitals. The fact is stressed that, for the first or second year, the unknown backlog of need may entail an expense above the amount estimated.

c. Administrative Costs. The estimated costs of administration includes the collection of funds, the salaries of the administrative staff for the central and local offices, the maintenance of offices and of adequate service and business records and the public and professional educational programs. Under the conditions that prevail in the Territory the costs of adequate administration should not exceed six percent of the costs of the hospital and physicians' care. The estimate for the costs of administration is $500,000.

d. Summary of Costs. In accordance with the preceding estimates the costs of a system of organized payment are estimated as follows:

Hospital Care	$ 4,950,000
Physicians' Services	4,800,000
Administration	500,000
Total	$10,250,000

2. Financing. There are various methods of financing the included services. Whichever may be adopted an annual fund amounting to $10,250,000 must be accumulated.

Two existing sources of taxation appear to lend themselves most satisfactorily to the collection of funds. One is the present two percent tax on wages and salaries; the other is the tax on net income. Utilizing both of these forms simplifies an otherwise complex administrative problem, that of establishing the line of demarcation at the level of the $5,000 annual income. In addition, the use of existing agencies of government to collect funds for the hospital and medical services reduces the costs of the process.

The Commission estimates that a levy of two and one half percent upon the first $5000 of wages, salaries or dividends will produce approximately $9,750,000. It recommends that the tax as to compensation be divided equally between the employee and employer, with each contributing one and one-fourth percent.

The contributory form of payment by employees and employers creates a problem with respect to Federal employees. The Federal government, as an employer, cannot contribute to a system of organized payment unless Congress adopts the necessary legislation. The alternatives, therefore, are for Federal employees to pay the total tax of two and one half percent or be excluded, as a group, from the system of organized payment. To permit Federal employees to accept or reject admission to the system on a voluntary basis would involve the danger of an adverse selection i.e. the possibility that many with known medical needs would choose to participate.

It is estimated that a two and one-half percent levy on the first $5000 of net incomes, with 100% credit for amounts paid under the compensation and dividends tax, would result in a sum amounting to $500,000. Added to the above $9,750,000 the total would be $10,250,000.

The Commission, in the preceding report, has presented the results of its deliberations over a period of about 15 months. The recommendations are presented to the Legislature and the people of the Territory not as a perfect solution but as a composite of the best judgement of the Commission members. The recommendations that have been made will be presented in the form of a bill that may be considered and analyzed by the members of the Legislature.

CHAPTER IV

BURIAL CHARGES AND BURIAL INSURANCE

Joint Resolution No. 12 by amendment to the original Resolution refers to the Hospital Service Study Commission the question of burial charges and the feasibility of a Territorial system of burial insurance, as well as the question of medical services and health insurance. Accordingly, the Commission has devoted several of its meetings to a consideration of this subject, including meetings with representatives from the mortuary establishments and with representatives from the Circuit Court judges.

The question as presented to the Commission has involved two aspects: (1) the feasibility of a territorial system of burial insurance and, (2) the question of burial charges as against small estates.

The Commission believes that a system of public burial insurance, using a pooled reserve fund out of which burial charges would be met, would not be feasible unless there were also established a system of controls for rates and services. However desirable this might be there appears to be no existing precedent for such control. Should the Commission suggest a system of public burial insurance which paid to the beneficiary a cash indemnity rather than a service benefit there would be little to recommend the system over commercial life insurance. On the other hand, should the Commission recommend a system based upon a service type of benefit, there would be a number of extremely complicating factors in determining the level of services. When surgery is required, the patient expects only one type of service and this is true even though the fees may vary as to individuals. Even in hospitals, the services demanded are within a relatively narrow range between ward and private room level. Demands for burial services, on the other hand, cover an extremely wide range of services (and therefore costs) and it should be noted that the level of service used is always the level "demanded" by the family even though in their state of bereavement they may be susceptible to an unjustifiable financial decision. Unfortunately, the factor of human psychology overweighs the factor of financial soundness.

The public's interest in the adequacy and nature of burial services is met, in part, through the police power of the government to license and to set standards for undertakers. Furthermore, public burial insurance distinguishes itself from medical care insurance in the following respects:

1. In the number of persons affected.

   Costs for burial services are incurred each year on behalf of 7 persons per thousand population.

   Costs for medical care (one or more illness) are incurred each year on behalf of 530 persons per thousand population.

2. The principle of insuring or spreading the cost of burials has not been generally accepted except to the extent of commercial insurance or mutual benefit associations.

3. From a study of a large number of recommendations and legislative proposals submitted to other governmental jurisdictions, federal and state, there appears to have been no widespread public demand for the inauguration of a system of public burial insurance.

In the light of the foregoing considerations the Commission believes that a Territorial system of public burial insurance is not feasible and it does not, therefore, recommend such adoption.

Apart from the question of public burial insurance, there was brought to the attention of the Commission the question of burial charges as against small estates. From evidence presented the Commission finds that there have been certain instances of abuse in the size of the charges made for burial services in the case of small estates (estates under $1500). The number of these abuses, although constituting serious hardships in individual cases, have not been such as to warrant public control. The Commission believes that it is within the province of the Circuit Court judges

(in reviewing the administration of small estates) to pass upon the reasonableness of burial charges and that a satisfactory policy in this regard is now in effect.

The Commission recognizes that this policy, based upon common law, might, if the legislature feels it desirable, be buttressed by a specific statute and that there is strong legal argument for such a statute. In view of the fact that the circuit court judges feel that there is no need at the present time for such a statute, the Commission makes no specific recommendation on this point and regards the matter as one primarily of legislative policy.

Documents relating to the question of burial charges as against small estates are appended in Part II for the attention of the legislature.

PART II

STATISTICAL APPENDIX AND DIGESTS

TABLE 1

POPULATION
TERRITORY OF HAWAII, 1778 - 1946

Year	Population	Year	Population	Year	Population
1778	300,000	1910	191,874	1936	393,277
1832	130,313	1920	255,912	1937	396,715
1836	108,579	1925	323,645	1938	411,485
1850	84,165	1926	328,444	1939	414,991
1853	73,138	1927	333,420	1940	423,330
1860	69,800	1928	348,767	1941	465,339
1866	62,959	1929	357,649	1942	474,351
1872	56,897	1930	371,250	1943	483,361
1878	57,985	1931	375,211	1944	492,379
1884	80,578	1932	380,507	1945	502,122
1890	89,990	1933	380,211	1946	519,503
1896	109,020	1934	378,948		
1900	154,001	1935	384,437		

SOURCE: Census and Board of Health estimates.

TABLE 2

CIVILIAN POPULATION, BY COUNTIES AND BY CITIES
TERRITORY OF HAWAII, 1940 - 1946

	1940	1941	1942	1943	1944	1945	1946
City of Honolulu	179,326	200,158	206,002	211,845	217,692	261,033	267,710
City & County of Honolulu, excl. of Honolulu City	78,930	110,345	115,035	119,724	124,414	87,012	91,201
City of Hilo	23,353	22,667	2/	24,158	24,904	28,308	27,922
County of Hawaii, excl. of Hilo	49,923	45,731	2/	42,904	41,491	41,741	42,949
County of Kalawao	(446)1/	464	2/	450	444	415	386
County of Kauai	35,818	33,479	2/	32,791	32,448	32,650	35,111
County of Maui	55,980	52,495	2/	51,489	50,986	50,963	54,225
Total Territory	423,330	465,339	474,351	483,361	492,379	502,122	519,504

1/ Included in the Maui County total.
2/ Not available.

SOURCE: 1940, Bureau of Census; Board of Health estimates, Oct. 28, 1946.

TABLE 3

POPULATION BY REPRESENTATIVE DISTRICTS AND BY CITIES, TOWNS AND VILLAGES WITHIN DISTRICTS TERRITORY OF HAWAII, 1940

Location	Population 1940
District No. 1	
Hamakua	8,244
Honokaa	1,132
Kukuihaile	408
Waipio	216
North Hilo District	4,468
Laupaheohoe	534
Ninole	77
Ookala	735
Papaaloa	662
Puna District	7,733
Kalapana	211
Kapoho	483
Keaau (Olaa)	2,509
Mt. View	955
Pahoa	1,114
South Hilo District	32,588
Hakalau	1,138
Hilo	23,353
Honomu	868
Papaikou	1,566
Wailea	414
District No. 2	
Kau District	5,581
Naalehu	1,038
Pahala	1,651
Waiohinu	214
North Kohala District	5,362
Hawi	1,194
Kapaau (Kohala)	1,255
Mahukona	147
Makapala	527
North Kona District	3,924
Holualoa	541
Kailua	381
Kainaliu	490
Kealakekua	117
South Kohala District	1,352
Kawaihae	123
Waimea (Kamuela)	445
South Kona District	4,024
Hookena	54
Kealakekua	256
Kealia	195
Milolii	66
Napoopoo	103
District No. 3	
Hana District	2,663
Hana	1,185
Keanae	106
Kalawao District	446
Lahaina District	8,291
Honokahua	729
Lahaina	5,217
Puukolii	1,042
Lanai District	3,720
Lanai City	3,597
Makawao District	14,915
Haiku	431
Keokea	454
Kokomo	208
Lower Paia	1,235
Makawao	903
Paia	4,272
Pauwela	465
Waiakoa	695
Molokai District	4,894
Hoolehua	1,050
Kaunakakai	722
Kaulapuu	641
Maunaloa	979
Pukoo	52
Wailuku District	21,051
Kahului	2,193
Puunene	4,456
Spreckelsville	2,634
Waikapu	643
Wailuku	7,319
District No. 4	
Honolulu	108,691
Koolaupoko	3,619
District No. 5	
Ewa District	30,602
Aiea	3,553
Ewa	3,570
Pearl City	1,938
Waipahu	6,906
District No. 5 (Continued)	
Kookauloa District	4,968
Hauula	411
Kahuku	2,251
Laie	761
Wahiawa District	22,417
Wahiawa	5,420
Waialua District	8,397
Haleiwa	1,849
Waialua	2,512
Waianae District	2,948
Lualualei	371
Nanakuli	777
Waianae	1,078
Honolulu	70,667
Koolaupoko	5,387
District No. 6	
Hanalei District	2,065
Hanalei	313
Kilauea	548
Kawaihau District	6,512
Anahola	367
Kapaa	2,828
Kealia	758
Koloa District	8,493
Eleele	1,184
Kalaheo	770
Koloa	1,903
Wahiawa Mill	771
Lihue District	7,896
Hanamaulu	1,337
Lihue	4,254
Puhi	886
Waimea District	10,852
Hanapepe	1,166
Kekaha	2,536
Makaweli	1,010
Waimea	1,921

SOURCE: Bureau of Census

TABLE 4

POPULATION BY RACE
TERRITORY OF HAWAII, 1940 AND 1946

Race	1940	1946
Hawaiian	14,375	10,887
Part-Hawaiian	49,935	64,161
Puerto-Rican	1/	9,298
Caucasian	103,791	173,533
Chinese	28,774	30,286
Japanese	157,905	168,463
Korean	1/	7,092
Filipino	52,569	54,519
All others	15,981	1,264
Total Territory	423,330	519,503

1/ Not classified.

SOURCE: 1940, Bureau of Census; 1946, Board of Health estimate.

TABLE 5

POPULATION BY RACE AND BY COUNTIES
TERRITORY OF HAWAII, 1940

Race	Total	County of Hawaii	City & County of Honolulu	County of Maui	County of Kauai
Total, all races	423,330	73,276	258,256	37,876	53,922
Hawaiian	14,375	3,451	7,090	2,946	888
Part-Hawaiian	49,935	7,901	31,453	2,666	7,915
Caucasian	103,791	9,821	82,516	4,465	6,989
Chinese	28,774	1,832	24,567	862	1,513
Filipino	52,569	12,845	19,066	10,149	10,509
Japanese	157,905	34,865	83,387	15,470	24,183
All Others	15,981	2,561	10,177	1,318	1,925

SOURCE: Bureau of Census.

TABLE 6

POPULATION BY AGE GROUPS AND BY SEX
TERRITORY OF HAWAII, 1940

Age	Total	Male		Female	
		Number	Percent	Number	Percent
All Ages	423,330	245,135	100.00	175,195	100.00
Under 5 years	40,085	20,411	8.33	19,674	11.04
5 to 9 years	43,431	21,951	8.96	21,480	12.05
10 to 14 years	47,494	24,110	9.84	23,384	13,12
15 to 19 years	48,338	26,359	10.75	21,979	12.33
20 to 24 years	51,077	32,044	13.07	19,033	10.68
25 to 29 years	42,329	27,114	11.06	15,215	8.53
30 to 34 years	33,387	21,571	8.79	11,816	6.63
35 to 39 years	28,888	17,969	7.33	10,919	6.18
40 to 44 years	22,111	12,963	5.29	9,148	5.13
45 to 49 years	17,487	9,648	3.94	7,839	4.39
50 to 54 years	15,116	9,422	3.84	5,694	3.19
55 to 64 years	20,518	12,911	5.27	7,607	4.26
65 to 74 years	10,112	6,767	2.76	3,345	1.87
75 years and over	2,802	1,792	.73	1,010	.57
Not reported	155	103	.04	52	.03

SOURCE: Bureau of Census.

TABLE 7

POPULATION BY AGE GROUPS AND BY SEX
CITY AND COUNTY OF HONOLULU, 1940

Age	Total	Male		Female	
		Number	Percent	Number	Percent
All ages	179,326	94,734	100.00	84,592	100.00
Under 5 years	16,947	8,649	9.13	8,298	9.81
5 to 9 years	17,919	9,062	9.56	8,857	10.47
10 to 14 years	19,636	9,964	10.52	9,672	11.43
15 to 19 years	20,293	10,429	11.01	9,864	11.66
20 to 24 years	21,342	11,207	11.83	10,135	11.98
25 to 29 years	18,165	9,713	10.25	8,452	9.99
30 to 34 years	14,069	7,530	7.95	6,539	7.73
35 to 39 years	12,380	6,720	7.09	5,660	6.69
40 to 44 years	9,571	5,083	5.36	4,488	5.30
45 to 49 years	7,665	3,920	4.14	3,745	4.43
50 to 54 years	6,545	3,804	4.02	2,741	3.24
55 to 64 years	9,077	5,291	5.59	3,786	4.48
65 to 74 years	4,353	2,596	2.74	1,757	2.08
75 years and over	1,291	717	.76	574	.68
Not reported	73	49	.05	24	.03

SOURCE: Bureau of Census.

ESTIMATES OF FAMILY SIZE

Bureau of the Census figures for the Territory of Hawaii do not include a count for number of families; consequently, there are no accurate figures for average family size.

Estimate based upon other factors shows the average family size for the entire Territory to be approximately 4.6 persons per family.

This estimate is arrived at by a combination of two methods. The average number of persons per family in the wage and clerical class, as determined by the Department of Labor survey in 1943, 1/ was five persons. This included only families of two or more persons. Adjusting this figure by applying the U. S. Census percentage of 10.1 as the percentage that single person families are of all families, gives an average family size of 4.59 including single person families for the Territory of Hawaii.

The other method gives somewhat similar results by applying to Hawaii's known number of persons per dwelling unit, the U. S. Census ratio between number of persons per family and the number of persons per dwelling unit. For the United States the median number of persons per family was 3.15, or a ratio of 1 to 0.96. Applying this ratio to Hawaii's number of persons per dwelling unit, 4.87 for 1940, gives an average family size of 4.67.

1/ Monthly Labor Review, April, 1944.

TABLE 8

NUMBER AND AGE OF MEMBERS IN FAMILIES OF WAGE AND CLERICAL CLASS HONOLULU, MONTH OF JUNE, 1943

Percent of Families Having:	
2 members	11%
3 or 4 members	37%
5 or 6 members	27%
7 or more members	25%
All families	100%
Average Number of Persons per Family:	
14 years of age and older	3.3
Under 14 years	1.7
Total	5.0

SOURCE: Monthly Labor Review, April, 1944, p. 4.

TABLE 9

AVERAGE NUMBER OF PERSONS PER HOUSEHOLD* TERRITORY OF HAWAII, COUNTIES AND CITIES OF HONOLULU AND HILO

Locality	1920	1930	1940
Territory of Hawaii	3.90	4.78	4.87
Hawaii County	3.47	4.14	4.63
Honolulu County	4.31	5.13	5.01
Kauai County	3.70	4.50	4.47
Maui County	3.67	4.75	4.88
Hilo City	4.72	4.85	4.96
Honolulu City	4.43	5.02	4.65

* Occupied dwelling units
SOURCE: Bureau of Census 1940 - Housing.

TABLE 10

FAMILIES BY SIZE
UNITED STATES, 1940 AND 1930

Size of Family	1940		1930	
	Number	Percent	Number	Percent
All families	35,088,840	100.00	29,904,663	100.0
1 person in family	3,546,720	10.1	2,357,463	7.9
2 persons in family	9,008,680	25.7	6,982,835	23.4
3 persons in family	7,700,860	21.9	6,226,519	20.8
4 persons in family	6,153,620	17.5	5,234,696	17.5
5 persons in family	3,733,340	10.6	3,574,362	12.0
6 persons in family	2,168,200	6.2	2,273,300	7.6
7 persons in family	1,235,380	3.5	1,393,356	4.7
8 persons in family	700,520	2.0	842,669	2.8
9 or more in family	841,520	2.4	1,019,463	3.4
9 persons in family	1/		493,174	1.6
10 persons in family	1/		272,068	0.9
11 persons in family	1/		138,816	0.5
12 or more in family	1/		115,405	0.4
Median size of family	3.15		3.40	

1/ Statistics for 1940 not available.

SOURCE: Bureau of Census.

TABLE 11

BIRTHS AND INFANT MORTALITY, BY COUNTIES
TERRITORY OF HAWAII, 1945

Locality	By Usual Place of Residence		
	Births	Rate per 1,000 Population	Infant Deaths
Territory	12,597	25.5	383
City, Honolulu	7,551	29.1	230
City & Co. of Honolulu excl. of Honolulu City	1,624	19.8	61
City of Hilo	641	23.7	18
County of Hawaii (excl. Hilo City)	935	22.0	22
County of Kalawao	4	9.2	...
County of Kauai	680	21.0	19
County of Maui	1,162	22.9	33

SOURCE: Annual Report, Board of Health.

TABLE 12
NUMBER OF WORKERS AND TOTAL WAGES PAID BY INDUSTRY DIVISION FOR WORKERS COVERED BY UNEMPLOYMENT COMPENSATION TERRITORY OF HAWAII, 1943 - 1945

Industry Division	Covered Workers (Average Monthly)			Total Wages Paid		
	1943	1944	1945	1943	1944	1945
Total All Industries	81,021	76,502	79,354	$170,810,598.15	$164,486,429.43	$178,431,538.63
Agriculture, Forestry, Fisheries	62	62	60	84,807.33	86,670.09	87,741.06
Mining and Quarrying	266	333	357	611,788.59	990,128.63	1,089,651.98
Construction	14,406	5,698	6,306	43,957,248.52	17,006,300.73	18,618,095.76
Manufacturing	24,884	25,144	24,334	43,832,241.57	48,252,216.77	52,425,176.04
Transportation, Communication Utilities	10,094	10,352	9,641	24,663,004.18	28,227,477.12	26,441,509.54
Wholesale and Retail Trade	20,501	22,784	23,324	39,335,959.34	47,082,586.74	49,776,487.65
Finance, Insurance and Real Estate	2,137	2,218	2,356	5,286,821.14	6,043,464.47	6,793,824.20
Service Industries	8,667	9,907	12,971	13,033,277.48	16,793,429.88	23,193,532.40
Establishments, N.E.C.	4	4	5	5,450.00	4,155.00	5,520.00

SOURCE: Department of Labor and Industrial Relations, Territory of Hawaii.

TABLE 13
MAJOR OCCUPATION GROUP OF EMPLOYED PERSONS (EXCEPT PUBLIC EMERGENCY WORK) BY RACE TERRITORY OF HAWAII, 1940

Major Occupation Group	Total	Hawaiian	Part-Hawaiian	Caucasian	Chinese	Filipino	Japanese	Other Races
Total	180,796	4,539	11,141	56,419	10,688	32,132	60,973	4,914
Professional workers	9,492	149	971	4,714	967	123	2,395	173
Semiprofessional workers	1,411	21	161	529	147	67	453	33
Farmers & farm managers	3,554	118	136	306	140	189	2,587	78
Proprietors, managers & officials, except farm	11,522	142	539	4,739	1,346	290	4,186	280
Clerical, sales, and kindred workers	18,711	177	1,499	5,823	3,094	583	7,272	263
Craftsmen, foremen, and kindred workers	15,991	447	1,411	3,999	848	767	8,097	422
Operatives and kindred workers	19,081	943	2,251	3,798	1,407	2,614	7,288	780
Domestic service workers	8,520	117	400	669	240	467	6,342	285
Service workers, except Domestic	36,460	419	1,101	27,623	1,194	1,596	4,112	415
Farm laborers (wage workers) & farm foremen	36,232	591	803	1,860	398	22,101	10,212	1,267
Farm laborers (unpaid family workers)	2,760	32	74	83	48	77	2,412	34
Laborers, except farm and mine	15,489	1,359	1,723	2,145	850	3,205	5,375	832
Occupation not reported	573	24	62	131	9	53	242	52

SOURCE: Bureau of Census 1940, Series II, Population.

TABLE 14

CLASS OF WORKER OF EMPLOYED PERSONS (EXCEPT PUBLIC EMERGENCY WORK) TERRITORY OF HAWAII, 1940

Class of Worker	Total	Male	Female	Percent Distribution		
				Total	Male	Female
Total employed	180,796	145,659	35,137	100.0	100.0	100.0
Wage or Salary workers	158,525	131,731	26,794	87.7	90.4	76.3
Employers and own-account workers	15,967	11,659	4,308	8.8	8.0	12.3
Unpaid family workers	5,725	1,981	3,744	3.2	1.4	10.7
Class of worker not reported	579	288	291	0.3	0.2	0.8

SOURCE: Bureau of Census 1940, Series II, Population.

TABLE 15

LABOR FORCE OR GAINFUL WORKERS, BY AGE AND SEX TERRITORY OF HAWAII, 1940

Age	Population			Persons in labor force or gainful workers		
	Total	Male	Female	Total	Male	Female
Territory total, 14 and over	301,686	183,448	118,238	188,232	151,648	36,584
14 and 15 years	19,140	9,757	9,383	1,118	765	353
16 and 17 years	18,111	9,113	8,998	4,515	2,761	1,754
18 and 19 years	20,453	12,274	8,179	12,330	9,102	3,228
20 to 24 years	51,077	32,044	19,033	38,081	29,809	8,272
25 to 34 years	75,716	48,685	27,031	56,511	47,313	9,198
35 to 44 years	50,999	30,932	20,067	37,169	29,898	7,271
45 to 54 years	32,603	19,070	13,533	22,315	17,744	4,571
55 to 64 years	20,518	12,911	7,607	12,100	10,499	1,601
65 to 74 years	10,112	6,767	3,345	3,652	3,352	300
75 years and over	2,802	1,792	1,010	350	326	24
Not reported	155	103	52	91	79	12

SOURCE: Bureau of Census 1940, Population Series II, Table 10.

TABLE 16

LABOR FORCE OR GAINFUL WORKERS, BY AGE AND SEX
CITY OF HONOLULU, 1940

Age	Population			Persons in labor force or gainful workers		
	Total	Male	Female	Total	Male	Female
Honolulu City Total 14 & over	128,687	69,051	59,636	73,817	53,823	19,994
14 and 15 years	7,902	4,057	3,845	282	198	84
16 and 17 years	7,945	3,973	3,972	1,601	918	683
18 and 19 years	8,277	4,359	3,918	4,315	2,704	1,611
20 to 24 years	21,349	11,214	10,135	14,729	9,916	4,813
25 to 34 years	32,249	17,258	14,991	22,190	16,561	5,629
35 to 44 years	21,958	11,810	10,148	15,297	11,306	3,991
45 to 54 years	14,213	7,727	6,486	9,318	7,063	2,255
55 to 64 years	9,077	5,291	3,786	4,767	4,004	763
65 to 74 years	4,353	2,596	1,757	1,172	1,028	144
75 years and over	1,291	717	574	107	92	15
Not reported	73	49	24	39	33	6

SOURCE: Bureau of Census 1940, Population Series II, Table 10.

TABLE 17

POPULATION, HAWAIIAN SUGAR PLANTATION EMPLOYEES AND FAMILIES (INCLUDING PLANTERS), BY RACE, SEX AND ISLAND TERRITORY OF HAWAII, 1945

	Total	Island of Hawaii	Island of Oahu	Island of Maui	Island of Kauai
All races	73,593	25,828	18,287	15,671	13,807
Male	26,631	9,816	6,375	4,965	5,475
Female	16,951	5,249	4,746	3,861	3,095
Children	30,011	10,763	7,166	6,845	5,237
Hawaiian	2,003	724	378	512	389
Male	513	188	89	138	98
Female	470	167	90	127	86
Children	1,020	369	199	247	205
Caucasian (Anglo-Saxon)	2,287	672	664	475	476
Male	800	236	228	179	157
Female	781	224	236	160	161
Children	706	212	200	136	158
Chinese	839	287	201	185	166
Male	356	101	88	76	91
Female	160	50	42	42	26
Children	323	136	71	67	49
Filipino	21,169	7,682	5,854	2,852	4,781
Male	10,977	4,470	2,458	1,372	2,677
Female	2,692	781	996	353	562
Children	7,500	2,431	2,400	1,127	1,542
Japanese	37,229	13,223	9,343	8,624	6,039
Male	11,018	3,828	2,935	2,435	1,820
Female	10,305	3,294	2,856	2,395	1,760
Children	15,906	6,101	3,552	3,794	2,459
Korean	421	145	131	76	69
Male	231	111	49	27	44
Female	66	12	33	14	7
Children	124	22	49	35	18
Portuguese	6,822	2,275	1,175	2,016	1,356
Male	1,984	655	380	529	420
Female	1,858	552	348	595	363
Children	2,980	1,068	447	892	573
Puerto Rican	2,087	635	448	587	417
Male	593	192	124	146	131
Female	488	142	111	130	105
Children	1,006	301	213	311	181
All other	736	185	93	344	114
Male	159	35	24	63	37
Female	131	27	34	45	25
Children	446	123	35	236	52

SOURCE: HSPA, Census of Hawaiian Sugar Plantations, June 30, 1945.

TABLE 18

INCOME LEVELS OF FAMILIES
UNITED STATES, 1945

Family Income Bracket	Number of Families	Percent of Total
Under $1,000	9,300,000	20.2
1,000 to 1,999	12,400,000	27.0
2,000 to 2,999	10,300,000	22.4
3,000 to 3,999	7,000,000	15.2
4,000 to 4,999	3,100,000	6.8
5,000 to 7,499	2,200,000	4.8
7,500 and over	1,200,000	3.6
Total	45,500,000	100.0

SOURCE: United States News, July 26, 1946.

TABLE 19

PERCENTAGE DISTRIBUTION OF ANNUAL FAMILY INCOMES
UNITED STATES, 1928, 1935-6 AND 1942

Income Groups	1928	1935-6	1942
Under $2,000	49.8	79.1	49.9
2,000 to 3,000	24.6	12.9	20.4
3,000 to 5,000	15.7	5.4	20.2
5,000 to 10,000	7.0	1.7	7.2
Over 10,000	2.9	.9	2.3
Total	100.0%	100.0%	100.0%

SOURCE: Statistical Abstracts of the U. S.

TABLE 20

PER CAPITA INCOME PAYMENTS TO INDIVIDUALS BY STATES AND TERRITORY OF HAWAII, 1945

State	Percent of National Per Capita Income	Per Capita Income Payments to Individuals	State	Percent of National Per Capita Income	Per Capita Income Payments to Individuals
United States	100	$1,150			
New England			New Mexico	71	$ 812
Connecticut	126	1,449	Oklahoma	77	889
Maine	91	1,051	Texas	80	917
Massachusetts	115	1,321			
New Hampshire	84	971	Central		
Rhode Island	110	1,268	Illinois	117	1,360
Vermont	89	1,023	Indiana	100	1,152
			Iowa	96	1,109
Middle East			Michigan	105	1,212
Delaware	120	1,381	Minnesota	92	1,061
D. C.	118	1,361	Missouri	92	1,063
Maryland	105	1,212	Ohio	112	1,289
New Jersey	119	1,373	Wisconsin	101	1,161
New York	139	1,595			
Pennsylvania	104	1,199	Northwest		
West Virginia	73	839	Colorado	96	1,100
			Idaho	92	1,054
Southeast			Kansas	97	1,113
Alabama	61	700	Montana	102	1,172
Arkansas	57	654	Nebraska	97	1,117
Florida	87	996	North Dakota	98	1,123
Georgia	65	745	South Dakota	94	1,083
Kentucky	64	735	Utah	89	1,023
Louisiana	68	785	Wyoming	95	1,096
Mississippi	48	556			
No. Carolina	64	732	Far West		
So. Carolina	58	663	California	129	1,480
Tennessee	71	813	Nevada	108	1,243
Virginia	79	903	Oregon	110	1,266
			Washington	122	1,407
Southwest					
Arizona	80	918	Hawaii	97	1,121

SOURCE: U. S. Department of Commerce, Survey of Current Business, August, 1946. Hawaii estimated.

TABLE 21

NUMBER OF RETURNS AND TOTAL NET INCOME
U. S. PERSONAL INCOME TAX RETURNS, BY INCOME GROUPS
TERRITORY OF HAWAII, 1942

Net Income Class	Number of Returns	Percent of Total Returns	Net Income	Percent of Total Net Income
Form 1040-A[1/]	112,110	68.2	$208,947,503	50.0
Form 1040				
Under $500	849	.5	277,191	.1
500 to 750	792	.5	513,360	.1
750 to 1,000	982	.6	870,764	.2
1,000 to 1,250	1,387	.9	1,581,263	.4
1,250 to 1,500	1,674	1.0	2,311,649	.6
1,500 to 1,750	1,479	.9	2,388,600	.6
1,750 to 2,000	1,898	1.2	3,529,375	.9
2,000 to 2,250	1,430	.9	3,041,002	.7
2,250 to 2,500	1,428	.9	3,413,400	.8
2,500 to 2,750	1,509	.9	3,934,932	.9
2,750 to 3,000	2,855	1.7	8,316,380	2.0
3,000 to 3,500	13,774	8.3	44,587,745	10.7
3,500 to 4,000	7,527	4.6	28,105,363	6.7
4,000 to 4,500	5,508	3.4	23,306,653	5.6
4,500 to 5,000	3,050	1.9	14,337,706	3.4
5,000 to 6,000	2,219	1.3	12,011,203	2.9
Above 6,000	3,814	2.3	56,108,307	13.4
TOTALS	164,285	100.0	$417,582,396	100.0%

1/ Optional returns for gross incomes under $3,000.

SOURCE: U. S. Treasury Department, Statistics of Income, 1942.

TABLE 22

ESTIMATED NUMBER OF TAXPAYERS AND TAX BASE FOR SPECIFIED INCOME BRACKETS UNDER TERRITORIAL 2% TAX TERRITORY OF HAWAII, 1945

Income Bracket	Number of Taxpayers	Percent of Total 1/	Tax Base	Percent of Total 1/	Tax Collections
1 - 1,000	137,200	49	$ 46,440,000	12	$ 928,800
1,001 - 2,000	64,400	23	77,400,000	20	1,548,000
2,001 - 3,000	42,000	15	96,750,000	25	1,935,000
3,001 - 4,000	19,600	7	77,400,000	20	1,548,000
4,001 - 5,000	11,200	4	54,180,000	14	1,083,600
5,001 & above	5,600	2	34,830,000	9	696,600
Sub-total	280,000	100	387,000,000	100	7,740,000
Dividends	---	---	26,000,000	---	520,000
Total	---	---	413,000,000	---	8,260,000

1/ 1943 percentages applied to 1945-46 tax base and collections.

SOURCE: Territorial Tax Office.

TABLE 23

AVERAGE WEEKLY WAGE PAID BY INDUSTRY DIVISION FOR WORKERS COVERED BY UNEMPLOYMENT COMPENSATION TERRITORY OF HAWAII, 1939 - 1945

Industries	1939	1940	1941	1942	1943	1944	1945 1/
All Industries	$18.65	$23.25	$26.31	$37.33	$40.54	$41.35	$41.07
Agr., Forestry, fishing	10.06	11.56	13.48	18.44	26.21	26.88	28.14
Mining	15.45	18.65	32.67	41.56	44.23	57.17	57.46
Construction	19.73	24.40	31.48	46.94	58.67	57.40	58.52
Manufacturing	13.91	21.12	21.23	27.96	33.86	36.90	38.28
Transportation, util.	27.58	30.40	34.92	42.15	46.98	52.44	52.62
Wholesale, retail trade	22.34	22.79	25.48	32.75	36.90	39.73	38.27
Finance, ins., real estate	34.52	35.62	37.92	41.25	47.58	52.40	52.56
Services	19.06	19.19	20.10	25.10	28.92	32.60	32.20
Establishments N.E.C.	14.02	5.02	38.56	25.06	26.69	19.98	23.46

1/ First 6 months of 1945 only.

SOURCE: Department of Labor and Industrial Relations.

TABLE 24

AVERAGE MONTHLY NUMBER OF WORKERS COVERED BY UNEMPLOYMENT COMPENSATION TERRITORY OF HAWAII, 1939, 1942, 1945

Industries	1939 Pre-War	1942 Peak	Jan. to June 1945
All Industries	73,285	99,978	74,453
Agr., forestry, fishing	73	42	54
Mining	37	226	362
Construction	5,311	36,712	5,177
Manufacturing	34,791	24,889	23,587
Transportation, util.	7,087	9,573	9,421
Wholesale, retail trade	17,943	19,519	22,137
Finance, insurance, real estate	1,771	2,031	2,182
Services	6,241	6,979	11,528
Establishments N.E.C.	31	7	5

SOURCE: Department of Labor and Industrial Relations.

TABLE 25

AVERAGE MONEY INCOME, EXPENDITURES, AND SAVINGS OF FAMILIES AND SINGLE PERSONS IN CITIES, BY INCOME CLASS UNITED STATES, 1944

Item	Annual money income after personal taxes								
	Under $500	$500 to $1,000	$1,000 to $1,500	$1,500 to $2,000	$2,000 to $2,500	$2,500 to $3,000	$3,000 to $4,000	$4,000 to $5,000	$5,000 and over
Percent of families in each class	4.2	7.7	7.1	11.9	13.9	13.2	19.9	9.6	12.5
Money income after personal taxes 1/	$291	$764	$1,243	$1,769	$2,251	$2,747	$3,481	$4,406	$7,634
Expenditures for current consumption	594	939	1,317	1,690	1,946	2,375	2,816	3,428	4,324
Food 2/	235	368	506	646	747	908	1,034	1,147	1,383
Clothing	41	82	157	231	268	353	456	621	836
Housing, 3/ fuel, lt. ref.	178	231	285	328	379	424	484	546	635
Household operation	33	50	64	81	89	109	140	166	306
Furn., equipment	5	24	33	43	52	84	92	131	159
Automobile	6	13	36	42	61	104	122	175	171
Other transportation	6	21	28	47	53	52	63	83	114
Medical care	48	67	78	93	95	119	147	191	260
Personal care	12	20	34	42	46	55	64	84	109
Recreation	5	15	25	45	52	62	82	104	137
Tobacco	7	16	25	40	40	47	58	70	75
Reading	8	11	15	18	21	27	32	38	43
Formal education	1	2	1	8	8	14	13	29	41
Other	9	19	30	26	35	17	29	43	55
Personal taxes 1/	1	23	70	124	198	283	407	564	2,357
Gifts & contributions	17	31	52	82	92	136	127	211	454
Net savings or deficit	-320	-206	-126	-3	213	236	538	767	2,856
War bonds 4/	16	62	40	117	163	230	323	414	1,193
Life & annuity ins.	10	20	43	50	64	80	108	141	269
Other 5/	-346	-288	-209	-170	-14	-74	107	212	1,394
Average number of persons 6/	1.42	1.82	2.11	2.55	2.77	3.00	3.61	3.97	4.02
Average no. of earners 7/	.38	.68	1.07	1.16	1.22	1.28	1.56	1.96	2.08

1/ Personal taxes (income, poll, and personal property) have been deducted from income. Total money income may be obtained by combining the amounts shown on line 2 with those for personal taxes. Inheritances and large gifts are not considered current income; inheritances and gift taxes taxes are excluded from personal taxes.

2/ Includes expenditures for alcoholic beverages.

3/ Includes rents for tenant-occupied dwellings and for lodging away from home; and current operation expenses of home owners. Excludes principal payments on mortgages on owned homes.

4/ Value of bonds purchased less those cashed.

5/ These figures represent the differences between income and expenditures plus net war bond purchases and insurance premium payments. Included as savings are amounts deducted for social security, retirement plans, etc., not available separately.

6/, 7/ See table 26, page 56.

SOURCE: Monthly Labor Review, Jan. 1946, p. 2.

TABLE 26

AVERAGE MONEY INCOME, EXPENDITURES, AND SAVINGS OF FAMILIES OF TWO OR MORE PERSONS, IN CITIES, BY INCOME CLASS UNITED STATES, 1944

Item	Annual money income after personal taxes									
	Under $500	$500 to $1,000	$1,000 to $1,500	$1,500 to $2,000	$1,950 "break even" point	$2,000 to $2,500	$2,500 to $3,000	$3,000 to $4,000	$4,000 to $5,000	$5,000 and over
Percent of families in each class	1.5	5.2	5.3	10.7	...	14.0	14.7	23.0	11.2	14.4
Money income after personal taxes[1]	$313	$776	$1,243	$1,779	$1,950	$2,259	$2,757	$3,480	$4,408	$7,595
Expenditures for current consump.	887	1,053	1,407	1,788	1,877	2,051	2,410	2,838	3,439	4,305
Food[2]	374	434	555	701	733	797	913	1,043	1,150	1,386
Clothing	42	80	163	234	250	283	364	462	623	848
Housing,[3] fuel, light, refrig.	257	251	298	341	359	394	430	488	547	616
Household oper.	56	47	66	83	87	93	110	140	166	295
Furn. & equip.	5	25	39	49	53	60	88	95	132	157
Automobile	16	19	29	42	52	69	105	119	177	171
Other transp.	7	20	26	44	46	50	51	63	84	109
Medical care	62	88	94	105	105	104	123	149	190	265
Personal care	21	19	33	41	43	48	56	65	84	110
Recreation	3	15	28	46	49	55	63	82	105	137
Tobacco	16	15	21	41	41	41	48	59	71	76
Reading	14	13	14	18	19	22	27	31	37	43
Formal education	1	2	2	11	10	9	15	13	29	42
Other	13	25	39	32	30	26	17	29	44	50
Personal taxes[1]	2	13	32	86	119	180	270	402	559	2,385
Gifts & contrib.	26	30	47	66	73	86	119	119	203	454
Net savings or deficit	-600	-307	-211	-75	0	122	228	523	766	2,836
War bonds[4]	15	81	28	82	105	147	233	316	410	1,206
Life & ann. Ins.	14	25	40	59	63	70	83	109	140	263
Other[5]	-629	-413	-279	-216	-168	-95	-88	98	216	1,367
Average number of persons[6]	2.45	2.45	2.78	3.03	3.05	3.10	3.13	3.69	4.01	4.13
Average number of earners[7]	.35	.72	1.15	1.22	1.24	1.27	1.31	1.57	1.97	2.12

1/, 2/, 3/, 4/, 5/ See preceding table (25), page 55.

6/ Family size is based on equivalent persons, with 52 weeks of family membership considered equivalent to 1 person; 26 weeks equivalent to 0.5 person, etc.

7/ A family member that worked for pay (as wage or salary worker or on his own account) at any time during the year was considered an earner.

SOURCE: Monthly Labor Review, Jan. 1946, p. 4.

TABLE 27

CIVILIAN OUTLAY FOR PERSONAL TAXES, SAVINGS, GIFTS AND MAJOR CATEGORIES OF CONSUMPTION UNITED STATES, 1941, 1942 VS. 1935-1936 1/

Item	1941			1942			1935-1936		
	Amount (millions)	Percent Total	Per Spending Unit	Amount (millions)	Percent Total	Per Spending Unit 3/	Amount (millions)	Percent Total	Per Spending Unit
Civilian money income 2/	$86,900	100.0	$2,091	$105,430	100.00	$2,558	$59,259	100.0	$1,502
Personal taxes 4/	2,000	2.3	48	4,300	4.1	104	889	1.5	23
Savings 5/	12,260	14.1	295	25,440	24.1	617	5,978	10.1	151
Gifts to organizations 6/	1,000	1.2	24	1,200	1.1	29	2,178	3.7	55
Total	$15,260	17.6	$ 367	$ 30,940	29.3	$ 750	$ 9,045	15.3	$ 229
Consumption Expenditures 7/									
Foods & beverages	22,400	25.8	540	25,200	23.9	613	16,865	28.5	428
Clothing	8,800	10.1	212	10,200	9.7	249	5,261	8.9	133
Housing & household fuel	11,800	13.6	284	12,410	11.8	301	9,506 8/	16.0	241
Household operation	3,020	3.5	73	3,440	3.2	83	5,285 9/	8.9	134
Household furnishings	4,750	5.4	114	4,600	4.4	112	1,422	2.4	36
Automobile transp.	7,040	8.1	169	3,600	3.4	87	3,781	6.4	96
Other transportation	1,420	1.6	34	1,770	1.7	43	884	1.5	22
Medical care	3,400	3.9	82	3,710	3.5	90	2,205	3.7	56
Personal care	1,370	1.6	33	1,500	1.4	36	1,032	1.7	26
Recreation	3,200	3.7	77	3,350	3.2	81	1,643	2.8	42
Tobacco	2,200	2.5	53	2,410	2.3	58	966	1.6	24
Reading	930	1.1	22	1,000	.9	24	551	.9	14
Education	840	1.0	20	800	.8	19	506	.9	13
Other items	470	.5	11	500	.5	12	307	.5	8
Total	$71,640	82.4	$1,724	$ 74,490	70.7	$1,808	$50,214	84.7	$1,273

1/ Estimates cover all civilian consumers except those living in institutions. Figures represent calendar years.

2/ The aggregate civilian money income as reported by the O.P.A. is conceptually and statistically quite different from the U. S. Dept. of Commerce estimate of national income, but is quite consistent with it.

3/ In 1942 there were slightly over 41 million civilian "spending units," consisting roughly of 33 million civilian families of two or more persons, and 8 million single civilians.

4/ Personal taxes shown include income taxes, poll taxes, and certain minor personal property taxes. Sales taxes, and indirect taxes on consumption are included under expenditures for goods and services.

5/ Savings are defined as the net change in assets and liabilities of the spending unit during the year.

6/ Gifts consist only of money contributions to the church, the Red Cross, and other institutions and funds.

7/ Consumption consists of money expenditures only (see also reference No. 2).

8/ Does not include household fuel.

9/ Includes household fuel.

SOURCE: "How Consumers Spend Their Income," A. Edwin Fein, Research Company of America.

TABLE 28

CITY FAMILY EXPENDITURES FOR MEDICAL CARE, BY INCOME GROUP UNITED STATES, 1944

Income Group	Average Annual Money Income of Group[1/]	Expenditures for medical Care	Percent of Total Expenditures	Average Number of Persons
Under $500	$ 291.00	$ 48.00	16.5	1.42
500 to 1,000	764.00	67.00	8.8	1.82
1,000 to 1,500	1,243.00	78.00	6.3	2.11
1,500 to 2,000	1,769.00	93.00	5.3	2.55
2,000 to 2,500	2,251.00	95.00	4.2	2.77
2,500 to 3,000	2,747.00	119.00	4.3	3.00
3,000 to 4,000	3,481.00	147.00	4.2	3.61
4,000 to 5,000	4,406.00	191.00	4.3	3.97
5,000 and over	7,634.00	260.00	3.4	4.02

1/ Money income after deduction of income, poll, and personal property taxes.

SOURCE: Expenditures and Savings of City Families in 1944, Monthly Labor Review, January, 1946, page 2.

TABLE 29

AVERAGE MONTHLY EXPENDITURE FOR MEDICAL CARE BY FAMILIES OF WAGE EARNERS AND CLERICAL WORKERS, BY NET MONEY INCOME CLASS HONOLULU, JUNE 1943

Income Class[1/]	Monthly Expenditure for Medical Care	Percent of Total Expenditures
All families	$16.59	6.1
$100 to $250	12.96	6.5
$250 to $350	13.42	5.6
$350 to $450	18.38	6.1
$450 and over	23.51	6.2

1/ Net money income in June after payroll deductions.

SOURCE: "Wartime Earnings and Spending in Honolulu, 1943." Monthly Labor Review, April, 1944.

TABLE 30

COMPARATIVE WEIGHTS FOR EXPENDITURE ITEMS OF FAMILY BUDGET HONOLULU AND U. S. CITIES, MARCH 15, 1943

Budget Item	Honolulu	U. S. Cities
Food	45.0%	41.8%
Clothing	14.9	12.1
Rent	6.8	17.3
Fuel, Electric, Ice	2.6	6.0
House Furnishings	2.7	3.1
Miscellaneous:		
Transportation	5.7	4.5
Medical	5.3	3.7
House operation	4.3	3.6
Recreation	9.9	5.3
Personal	2.8	2.6
Total	100.0%	100.0%

SOURCE: Territorial Department of Labor and Industrial Relations.

TABLE 31

PER CAPITA INCOME, AND POPULATION-PHYSICIAN RATIOS BY STATES AND TERRITORY OF HAWAII, 1940

State	Per Capita Income Payments	Population Per Physician	State	Per Capita Income Payments	Population per Physician
District of Columbia	$1,080	382	Missouri	$ 505	758
Delaware	896	803	Iowa	485	867
New York	863	511	Utah	480	995
Nevada	836	766	Arizona	473	890
Connecticut	827	688	Florida	471	925
California	805	630	HAWAII	455	1,267
New Jersey	803	704	Virginia	450	1,018
Massachusetts	766	608	Idaho	440	1,271
Illinois	726	683	Nebraska	433	834
Rhode Island	715	770	Kansas	422	871
Maryland	712	619	Texas	413	1,025
Michigan	649	855	South Dakota	376	1,276
Ohio	643	770	North Dakota	368	1,256
Washington	632	830	Louisiana	357	1,006
Pennsylvania	628	765	Oklahoma	356	1,043
Wyoming	605	1,105	New Mexico	356	1,245
Oregon	579	781	Tennessee	317	1,066
Montana	574	1,058	North Carolina	316	1,383
New Hampshire	546	876	Georgia	315	1,222
Indiana	541	883	Kentucky	308	1,115
Colorado	524	684	South Carolina	286	1,505
Vermont	521	778	Alabama	286	1,523
Wisconsin	516	922	Arkansas	252	1,161
Minnesota	509	819	Mississippi	202	1,635
Maine	509	951			

SOURCE: Monthly Labor Review, Dec. 1945, p. 1102. Hawaii data added.

TABLE 32

RATIO OF POPULATION TO PHYSICIANS IN ACTIVE PRACTICE TERRITORY OF HAWAII, BY COUNTIES AND ISLANDS, 1940

Area	Number 1/ of Physicians	1940 2/ Population	Population per Physician
Total Territory	334	423,330	1,267
Honolulu County	237	258,256	1,089
City of Honolulu	212	179,326	846
C & C, excl. Honolulu	25	78,930	3,157
Hawaii County	44	73,276	1,665
City of Hilo	20	23,353	1,168
County, excl. Hilo	24	49,923	2,080
Kauai County	22	35,818	1,628
Island of Kauai	22	35,636	1,620
Island of Niihau	0	182	---
Maui County	30	55,980	1,866
Island of Maui	24	46,919	1,955
Island of Lanai	2	3,720	1,860
Island of Molokai (excl. Kalawao County)	4	4,894	1,224
Kalawao County	1	446	446

1/ Board of Health published list of licensed physicians, March 23, 1940.

2/ Bureau of Census, 1940.

TABLE 33

RATIO OF POPULATION TO PHYSICIANS IN ACTIVE PRACTICE TERRITORY OF HAWAII, BY COUNTIES AND ISLANDS, 1946

Area	Number[1] of Physicians	1946[2] Population	Population per Physician
Total Territory	353	519,503	1,472
Honolulu County	263	358,911	1,364
City of Honolulu	238	267,710	1,125
C & C, excl. Honolulu	25	91,201	3,648
Hawaii County	44	70,071	1,593
City of Hilo	29	27,922	963
County, excl. Hilo	15	42,949	2,863
Kauai County	14	35,111	2,508
Maui County	31	54,225	1,749
Island of Maui	28	45,337	1,619
Island of Lanai	1	3,630	3,630
Island of Molokai (excl. Kalawao County)	2	5,258	2,629
Kalawao County	1	386	386

1/ Board of Health published list of licensed physicians, July 1, 1946.

2/ Board of Health estimates of population, October 28, 1946.

TABLE 34

LICENSED PHYSICIANS BY TYPE OF PRACTICE
TERRITORY OF HAWAII, 1946

Specialty	Oahu		Hawaii		Kauai County	Maui County			Kalawao County	Total
	Honolulu City	C & C, excl. Honolulu	City of Hilo	Hawaii Co., excl. Hilo		Isl. of Maui	Isl. of Lanai	Isl. of Molokai (excl. Kalawao Co.)		
Active										
Institutional	12	4	3	..	1	3	..	..	1	24
Board of Health	6	..	..	..	..	..	..	..	..	6
Plantation	..	8	..	9	7	8	1	..	..	33
Group	46	..	..	..	..	..	..	..	..	46
Individual	174	13	26	6	6	17	..	2	..	244
Total Active	238	25	29	15	14	28	1	2	1	353
Inactive										
Retired										13
Out of Terr.										2
Army & Navy										20
Total Inactive										35
Total - All										388

SOURCE: Board of Health published list of licensed physicians, Territory of Hawaii, as of July 1, 1946.

TABLE 35

LICENSED PHYSICIANS IN ACTIVE PRACTICE, BY SPECIALTY
TERRITORY OF HAWAII, 1946

Specialty	Oahu		Hawaii		Kauai County	Maui County			Kalawao County	Total
	Honolulu City	C & C excl. Honolulu	City of Hilo	Hawaii Co., excl. Hilo		Isl. of Maui	Isl. of Molokai (excl. Kalawao Co.)	Isl. of Lanai		
General Practice	81	18	18	13	11	17	2	1		161
Surgery	37	1	2	1		2				43
Eye, Ear, Nose, Throat	21		3		2	3				29
Obstetrics & Gynecology	19		1			1				21
Tuberculosis	13	1	3		1	3				21
Pediatrics	15	2	2							19
Internal medicine	15			1						16
Neuro-Psychiatry	8	2				1				11
Urology	6	1								7
X-ray	6									6
Pathology	5									5
Public Health	4									4
Dermatology and Syph.	4								1	5
Orthopedics	3									3
Hematology	1									1
Allergy						1				1
Total	238	25	29	15	14	28	2	1	1	353

Note: Tuberculosis includes diseases of chest and thoracic surgery. Internal medicine includes cardiology. Neuro-psychiatry includes neuro-surgery. X-ray includes radiology and roentgenology. Dermatology includes leprosy.

SOURCE: Hawaii Territorial Medical Association and Board of Health.

TABLE 36

LICENSED PHYSICIANS, ACTIVE AND INACTIVE, BY AGE GROUPS TERRITORY OF HAWAII, 1946

Locality	Total	Under 30	30 to 39	40 to 49	50 to 59	60 to 69	70 and over
Active							
City of Honolulu	238	9	79	96	38	11	5
City & Co., excl. Hono.	25	2	8	12	1	2	..
City of Hilo	29	1	8	12	4	4	..
Hawaii Co., excl. Hilo	15	1	8	5	1	..	..
Kauai County	14	2	4	6	1	1	..
Maui County							
Isl. of Maui	28	..	7	13	5	2	1
Isl. of Lanai	1	..	1	..	..	..	..
Isl. of Molokai (excl. Kalawao Co.)	2	..	2	..	..	..	..
Kalawao County	1	..	1	..	..	..	..
Total Active	353	15	118	144	50	20	6
Inactive							
Out of Territory	2	..	1	1	..	..	..
Retired	13	..	1	..	..	4	8
Army & Navy	20	3	13	2	2	..	..
Total Inactive	35	3	15	3	2	4	8
Total active and inactive	388	18	133	147	52	24	14

SOURCE: Hawaii Territorial Medical Association and Board of Health.

TABLE 37

LICENSED PHYSICIANS BY TYPE OF PRACTICE TERRITORY OF HAWAII, 1940

Locality	Total	Institutional	Board of Health	Plantation	Group	Individual	Total Active	Total Inactive
Honolulu City	217	19	6	--	36	151	212	5
Honolulu Co. (excl. Honolulu City)	27	6	--	10	--	9	25	2
City of Hilo	20	--	--	--	--	20	20	--
Hawaii Co. (excl. Hilo)	28	2	--	9	--	13	24	4
Kauai County	22	--	--	15	--	7	22	--
Maui County								
Isl. of Maui	25	3	--	11	--	10	24	1
Isl. of Lanai	2	--	--	2	--	--	2	--
Isl. of Molokai (excl. Kalawao Co.)	4	--	--	--	--	4	4	--
Kalawao County	1	1	--	--	--	--	1	--
Total	346	31	6	47	36	214	334	12

SOURCE: Board of Health published list of licensed physicians, Territory of Hawaii, March 23, 1940.

TABLE 38

OSTEOPATHS, CHIROPRACTORS AND NATUROPATHS IN ACTIVE PRACTICE TERRITORY OF HAWAII, 1946

Locality	Osteopaths	Chiropractors	Naturopaths
Total Territory	11	6	17
City of Honolulu	10	6	15
City of Hilo	--	--	2
Island of Maui	1	--	--

SOURCE: Secretaries of Examining Boards.

TABLE 39

DENTISTS IN ACTIVE PRACTICE AND DENTIST-POPULATION RATIOS TERRITORY OF HAWAII, 1946

Locality	Population[1]	Dentists[2]	Population per Dentist
Honolulu County			
City of Honolulu	267,710	151	1,773
C & C, excl. Honolulu	91,201	11	8,291
Total Honolulu County	358,911	162	2,216
Hawaii County	70,871	25	2,834
Kauai County	35,111	9	3,912
Maui County			
Island of Maui	45,337	9	5,037
Island of Lanai	3,630	1	3,630
Island of Molokai (excl. Kalawao County	5,258	1	5,258
Total Maui County	54,225	11	4,930
Kalawao County	386	0	--
Total Territory	519,503	207	2,510

1/ Revised civilian population estimates, Board of Health, October 28, 1946.

2/ Hawaii Territorial Dental Society annual report, 1946, p. 23.

TABLE 40

NUMBER OF HOSPITALS AND BED COMPLEMENT, BY OWNERSHIP TERRITORY OF HAWAII, 1946

Ownership	Number of Hospitals	Bed Complement	Percent of Beds
Non profit	12	1,662	29.0
Proprietary			
Individual	14	160	2.8
Corporation (Plantation)	21	783	13.7
Government			
City & County (3 tbc)	10	1,124	19.7
Terr. (Leprosy, N. & M.)	4	1,993	34.8
Total	61	5,722	100.0

SOURCE: Hospital Service Study Commission Survey of Hospitals, 1946.

TABLE 41

NUMBER OF HOSPITALS AND BED COMPLEMENT, BY TYPE AND SIZE TERRITORY OF HAWAII, 1946

Type & Size of Hospital	Number of Hospitals	Bed Complement	Percent of Beds
General hospitals			
Under 25 beds	13	185	
25 to 49 beds	15	543	
50 to 99 beds	7	499	
100 to 249 beds	4	580	
250 to 499 beds	1	370	
Total-General-hospitals	40	2,177	38.0
Maternity Hospitals			
Under 25 beds	2	12	
100 to 249 beds	1	105	
Total-Maternity Hospitals	3	117	2.1
Convalescent and chronic hospital and nursing homes			
Under 25 beds	6	52	
25 to 99 beds	1	52	
100 to 249 beds	1	176	
Total-Convalescent and chronic hospital and nursing homes	8	280	4.9
Pediatric	1	100	1.8
Orthopedic	1	28	.5
Tuberculosis	4	1,027	17.9
Nervous and mental	2	1,868	32.6
Leprosy	2	125	2.2
Total-others	10	3,148	55.0
Grand Total, all types	61	5,722	100.0

SOURCE: Hospital Service Study Commission Survey of Hospitals, 1946.

TABLE 42

DISTRIBUTION OF GENERAL AND ALLIED SPECIAL HOSPITAL BEDS, 1/ AND RATIO OF BEDS TO 1,000 POPULATION TERRITORY OF HAWAII, 1946

Locality	Bed 2/ Complement 1946	Population 3/ July 1 1946	Ratio of Beds to 1,000 Population
Hawaii County			
Hilo City	250	27,922	9.0
Hawaii, excl. Hilo	339	42,949	7.9
Total Hawaii County	589	70,871	8.3
Honolulu County			
Honolulu City	897	267,710	3.4
County, excl. Honolulu	318	91,201	3.5
Total Honolulu County	1,215	358,911	3.4
Kauai County	167	35,111	4.8
Maui County			
Island of Maui	378	45,337	8.3
Island of Lanai	26	3,630	7.2
Island of Molokai (excl. Kalawao Co.)	47	5,258	8.9
Total Maui County	451	54,225	8.3
Total Territory	2,422	519,503	4.7

1/ "General and allied special hospitals" includes maternity, pediatric and orthopedic; it excludes convalescent and chronic hospitals and nursing homes, mental, tuberculosis and leprosy hospitals.

2/ Hospital Service Study Commission Survey of Hospitals, 1946.

3/ Revised civilian population estimates, Board of Health, October 28, 1946.

TABLE 43

DISTRIBUTION OF PLANTATION HOSPITAL BEDS BY ISLANDS AND RATIO OF BEDS TO 1,000 PLANTATION POPULATION TERRITORY OF HAWAII, 1945

Island	Bed 1/ Complement 1945	Population 2/ 1945	Ratio Beds per 1,000 Pop.
Oahu	204	18,287	11.2
Hawaii	226	25,828	9.0
Maui	244	15,671	15.6
Kauai	64	13,807	4.6
Molokai	19	...	...
Lanai	26	3,630	7.2
Total	783	77,223	9.9

1/ Hospital Service Study Commission Survey of Hospitals, 1946.

2/ H.S.P.A. Census of Hawaiian Sugar Plantations, June 30, 1945.

TABLE 44

COMPARISON OF HOSPITAL BED RATIOS TERRITORY OF HAWAII WITH STANDARD RATIOS, 1946

Type of Hospital	Number of Beds	Territorial Ratio	Standard Ratio 1/
General	2,177	4.2	4.5 per 1,000 pop.
Pediatric & orthopedic	128		
Maternity	117		
	2,422	4.7	
Chronic & convalescent	280	.54	2.0 " " "
Nervous and mental	1,868	3.6	5.0 " " "
Tuberculosis	1,027	3.65	2.5 per ann. death

1/ Tentative ratios, U.S.P.H.S.

SOURCE: Hospital Service Study Commission Survey of Hospitals, 1946.

TABLE 45

UTILIZATION OF GENERAL AND ALLIED SPECIAL HOSPITALS 1/ TERRITORY OF HAWAII, BY ISLANDS, 1945

Island & Ownership	Bed Complement 1945	Patients Treated	Patient Pays	Percent Occupancy	Average Stay
Oahu					
Non-profit	805	31,934	263,601	89.7	8.3
Prop. Indiv.	11	312	1,969	49.0	6.3
Prop. Corp.	204	5,500	39,185	52.6	7.1
Total Oahu	1,020	37,746	304,755	81.8	8.1
Hawaii					
Prop. Indiv.	91	1,306	13,486	40.6	10.3
Prop. Corp.	226	3,625	33,995	41.2	9.4
Government	272	4,515	45,903	46.2	10.2
Total Hawaii	589	9,446	93,384	43.4	9.9
Kauai					
Non-profit	93	2,014	17,781	52.8	8.8
Prop. Indiv.	14	350	1,884	36.8	5.4
Prop. Corp.	60	1,208	11,645	53.2	9.6
Total Kauai	167	3,572	31,310	52.5	8.8
Maui					
Prop. Corp.	244	4,803	45,658	51.3	9.5
Government	134	2,835	24,137	49.3	8.5
Total Maui	378	7,638	69,795	50.6	9.1
Lanai					
Prop. Corp.	26	760	3,506	36.9	4.6
Molokai					
Non-profit	28	687	4,824	47.2	7.0
Prop. Corp.	19	337	1,339	19.3	4.0
Total Molokai	47	1,024	6,163	35.9	6.0
Total all islands	2,227	60,186	508,913	62.6	8.5

1/ "General and allied special hospitals" includes maternity, pediatric and orthopedic; it excludes convalescent and chronic hospitals and nursing homes, mental, tuberculosis and leprosy hospitals.

SOURCE: Hospital Service Study Commission Survey of Hospitals, 1946.

TABLE 46

UTILIZATION OF HOSPITALS, BY TYPE OF HOSPITAL TERRITORY OF HAWAII, 1945

Type of Hospital	Beds 1945	Patients Treated	Patient Days	Percent Occupancy	Average Stay
General	2,089	53,534	463,320	60.8	8.7
Non-profit	788	28,217	240,624	83.6	8.5
Prop. Indiv.	112	1,871	16,660	40.7	8.9
Prop. Corp.	783	16,096	135,996	47.6	8.4
Governmental	406	7,350	70,040	47.3	9.5
Allied Special					
Maternity	42	2,882	17,601	114.8	6.1
Pediatric	72	3,524	21,104	80.3	6.0
Orthopedic	28	109	8,030	78.5	74.0
Convalescent & Chronic	276	868	84,037	83.4	98.8
Tuberculosis	1,027	1,677	348,385	93.0	208.0
Mental	1,868	2,129	586,124	86.0	275.3
Leprosy	125	--	17,869	39.2	--

SOURCE: Hospital Service Study Commission Survey of Hospitals, 1946.

TABLE 47

COST PER HOSPITAL DAY, GENERAL AND ALLIED SPECIAL HOSPITALS TERRITORY OF HAWAII, 1945

County	Average per capita cost per day
Hawaii	9.96
Maui	9.34
Kauai	8.00
Oahu	10.83

SOURCE: Hospital Service Study Commission, Survey of Hospitals, 1946.

TABLE 48

ANNUAL ILLNESS RATES BY AGE AND SEX

Age	Combined Rates	Male	Female
Under 1	1.32	1.36	1.30
Under 5	1.24	1.25	1.23
5 - 9	.99	1.01	.96
10 - 14	.67	.68	.66
15 - 19	.58	.54	.62
20 - 24	.67	.44	.83
25 - 34	.82	.61	.98
35 - 44	.76	.61	.92
45 - 64	.75	.63	.91
Over 65	.87	.75	.96

TABLE 49

ILLNESS RATES FOR RELIEF AND LOW-INCOME FAMILIES BASED UPON THE INDEX OF ILLNESS AMONG FAMILIES WITH INCOMES ABOVE $5,000 (EXPRESSED AS AN INDEX OF 100)

Family Income	Illness Rates				
	Tuberculosis	Orthopedic Impairments	Rheumatism	Digestive Diseases	Nervous Diseases
Over $5,000	100	100	100	100	100
Relief	875	420	369	340	287
Under $1,000	388	283	213	180	204
$1,000 - $1,500	250	175	138	114	135

TABLE 50

AVERAGE ANNUAL INCIDENCE OF ILLNESS OCCURRING AMONG 1,000 PERSONS

Number of Illnesses	Number of Persons
No illnesses	470
One illness	322
Two illnesses	136
Three illnesses	48
Four illnesses	16
Five or more illnesses	7

Total illness per 1,000 - 840

Approximately 7% of the people reported 30% of all illnesses.

TABLE 51

ANNUAL COSTS OF ILLNESS PER PERSON BY AGE AND SEX 1/

Age	Combined	Male	Female
Under 1	$11.80	$12.88	$10.67
Under 5	12.26	12.64	11.87
5 - 9	15.56	16.69	14.40
10 - 14	14.39	14.23	14.56
15 - 19	16.98	14.88	19.07
20 - 24	24.36	15.28	33.16
25 - 34	29.33	15.32	43.20
35 - 44	27.18	17.59	37.34
45 - 64	27.19	22.16	32.63
Over 65	44.92	43.04	46.80
All	23.55	18.19	29.06

1/ Based on the records for 37,766 white persons in 8,639 families with known incomes, surveyed for 12 consecutive months, 1928-1931.

SOURCE: Committee on the Costs of Medical Care, No. 26, The Incidence of Illness and the Receipt and Costs of Medical Care Among Representative Family Groups, page 173.

TABLE 52

AVERAGE FAMILY EXPENDITURES FOR MEDICAL CARE BY SELECTED INCOME GROUPS

Income Groups	1929		1935-36		1941	
	Amount	Percent of Income	Amount	Percent of Income	Amount	Percent of Income
Under $500	--	--	$ 22	7.1	$ 26	8.3
1,000 - 1,250	--	--	47	4.2	--	--
Under 1,200	$ 49	5.2	--	--	--	--
1,200 - 2,000	67	4.0	--	--	--	--
2,000 - 2,500	--	--	91	4.1	96	4.3
2,000 - 3,000	95	3.9	--	--	110	4.3
3,000 - 4,000	--	--	132	3.9	--	--
3,000 - 5,000	138	3.8	--	--	153	4.1
4,000 - 5,000	--	--	158	3.6	--	--
5,000 - 10,000	249	4.1	248	3.6	236	3.8
Over 10,000	503	3.8	467	2.1	--	--
All	108	3.8	64	4.0	--	--

TABLE 53

AVERAGE PERCENTAGE OF FAMILY EXPENDITURES FOR MEDICAL SERVICES BY INCOME GROUPS, 1928-31

Income	Under 1200	1200 - 2000	2000 - 3000	3000 - 5000	5,000 - 10,000	Over 10,000	All
Total Cost	$49.00	$67.00	$95.00	$138.00	$249.00	$503.00	$108.00
Physician	44.5%	43.6%	41.5%	39.3%	35.6%	34.7%	39.8%
Hospital	17.7	13.9	14.4	11.6	10.5	12.5	13.0
Nurse	3.8	4.7	5.0	7.5	14.6	13.7	8.1
Dentist	8.4	13.5	17.3	20.4	22.1	26.0	18.5
Drugs	17.6	16.5	14.5	12.7	9.2	7.1	12.9
Refraction glasses	2.5	2.2	2.4	2.9	2.9	2.3	2.5
Secondary practitioners	3.5	1.9	2.1	1.8	2.9	1.7	2.2
Other	2.0	3.7	2.8	3.8	2.2	2.0	3.0
All	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

SOURCE: Committee on the Cost of Medical Care.

TABLE 54

VARIATIONS IN FAMILY EXPENDITURES FOR MEDICAL CARE BY INCOME GROUPS, 1928-31

Costs	Under $1,200	$1,200-2,000	$2,000-3,000	$3,000-5,000	$5,000-10,000	Over $10,000	All
Under $20	48.8%	34.4%	25.2%	16.7%	8.4%	2.6%	28.7%
$20 - $60	30.6	34.5	29.2	23.6	19.6	9.1	29.1
$60 - $200	15.8	24.0	33.0	40.6	36.1	30.2	28.6
$200 - $500	3.8	6.0	10.4	14.7	23.3	25.3	9.9
Over $500	1.0	1.1	2.2	4.4	12.6	32.8	3.7
	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Under $60 - 18% of total costs paid by 58% of the families.
$60 - $250 - 41% of total costs paid by 32% of the families.
Over $250 - 41% of total costs paid by 10% of the families.

SOURCE: Committee on the Cost of Medical Care.

TABLE 55

PHYSICIANS' HOME, OFFICE AND CLINIC CALLS PER 1,000 PERSONS, BY INCOME GROUPS

Service	Under $1,200	$1,200-2,000	$2,000-3,000	$3,000-5,000	$5,000-10,000	Over $10,000	All
Home	861.4	847.2	1,037.1	1,308.9	1,330.9	2,359.7	1,048.0
Office	821.0	1,110.7	1,286.2	1,524.1	2,489.9	2,918.6	1,326.3
Clinic	486.8	310.6	185.6	162.5	155.9	42.7	264.5
All	2,169.2	2,268.5	2,508.9	2,741.4	3,976.7	5,321.0	2,638.8

TABLE 56

ATTENDED ILLNESSES AND NUMBER OF HOME AND OFFICE CALLS

Number of Calls	Number of Cases	Percent Cases	Total Calls	Percent of Calls
1	9,607	40.1	9,607	9.4
2	4,696	19.6	9,392	9.2
3	2,683	11.2	8,049	7.9
4	1,533	6.4	6,132	6.0
5	1,030	4.3	5,150	5.0
6 - 7	1,318	5.5	8,567	8.4
8 - 9	767	3.2	6,520	6.4
10 - 14	1,078	4.5	12,936	12.7
15 - 19	479	2.0	8,143	8.0
20 - 29	431	1.8	10,775	10.6
30 or more	335	1.4	16,750	16.4
All	23,957	100.0	102,021	100.0

SOURCE: Selwyn D. Collins, Public Health Reports, October 10, 1941.

TABLE 57

PATIENTS AND PATIENT DAYS IN GENERAL HOSPITALS PER 1,000 POPULATION, BY INCOME GROUPS, 1928-31

Patients and Days	All Groups	Under $1,200	$1,200-2,000	$2,000-3,000	$3,000-5,000	$5,000-10,000	Over $10,000
Number of patients	59	59	50	58	63	75	106
Number of days	746	928	667	757	804	840	1,201

TABLE 58

COMPOSITION OF THE BILL FOR HOSPITALIZED CASES 1928 - 31

Family Income Group	Average Total Charge	Percent of Total Charge for:			
		Hospital	Physician	Special Nurse	All Other
Under $1,200	$ 67.39	46.1	43.5	5.0	5.4
1,200 - 2,000	102.51	40.8	45.8	6.8	6.6
2,000 - 3,000	140.08	38.6	47.3	7.4	6.7
3,000 - 5,000	167.86	33.6	42.2	8.5	15.7
5,000 - 10,000	265.40	31.7	43.5	13.2	11.6
Over 10,000	469.91	32.3	49.5	9.3	8.9
All	$139.14	39.0	45.2	7.5	8.3

NOTE: For all income groups the illnesses hospitalized accounted for approximately 50% of the total costs of care. Hospitalized cases ranged from 47.7% to 55.5% of the total costs for the various income groups. Non-hospitalized bed cases accounted for 29.1% of the total costs, ranging from 19.7% to 32.1% for the various income groups.

SOURCE: Committee on the Cost of Medical Care, No. 26, Incidence of Illness and Receipt and Costs of Medical Care . . . ., page 197.

TABLE 59

COMPOSITION OF THE BILL FOR HOSPITALIZED SURGICAL CASES BY FAMILY INCOME GROUPS

Family Income	Percent of All Hospital Cases	Average Total Charges	Percent of Total Charges for:			
			Hospital	Physician	Special Nurse	Other
Under $1,200	56.7	$ 81.07	40.8	47.8	6.7	4.7
1,200 - 2,000	61.3	119.46	35.8	50.0	8.8	5.4
2,000 - 3,000	65.8	156.27	33.2	47.1	8.4	11.3
3,000 - 5,000	63.3	165.82	30.8	48.3	8.1	12.8
5,000 - 10,000	68.9	258.97	27.8	44.4	13.8	14.0
Over $10,000	68.7	469.18	31.0	46.1	18.4	4.5
All	63.3	$150.21	34.4	48.2	8.9	8.5

TABLE 60

COMPOSITION OF THE BILL FOR HOSPITALIZED OBSTETRICAL CASES

Family Income	Percent of All Hospital Cases	Average Total Charges	Percent of Total Charges for			
			Hospital	Physician	Special Nurse	Other
Under $1,200	11.8	$ 82.76	54.4	30.3	0.3	
1,200 to 2,000	13.8	110.05	50.0	37.6	1.2	
2,000 - 3,000	14.7	144.81	46.8	40.2	5.2	
3,000 - 5,000	14.4	233.22	40.8	36.6	13.2	
5,000 - 10,000	9.8	349.71	33.0	31.7	17.0	
Over $10,000	7.0	978.00	16.7	31.9	15.4	

TABLE 61

NUMBER OF HOSPITALIZED ILLNESSES 1/ BY INCOME BRACKETS AND SIZE OF COMMUNITY

Income Group	Number of Hospitalized Illnesses. Occurring in								
	Cities of 100,000 Population & Over			Cities of 5,000-100,000 Population			Towns of Less Than 5,000 Population		
	Total Cases	Surg. Cases	Non-Surg. Cases	Total Cases	Surg. Cases	Non-Surg. Cases	Total Cases	Surg. Cases	Non-Surg. Cases
Under $1,200	71	41	30	99	54	45	148	91	57
1,200 - 1,999	283	170	113	147	93	54	249	153	96
2,000 - 2,999	266	183	83	148	88	60	140	98	42
3,000 - 4,999	153	95	58	81	53	28	70	44	26
5,000 & over	199	140	59	151	108	43	29	20	9
Total	972	629	343	626	396	230	636	406	230

1/ Excludes persons in mental and tuberculosis hospitals and in resident institutions for care of other chronic diseases; includes 38,668 persons in 8,639 white families.

SOURCE: Social Security Board, Bureau of Research and Statistics, Memorandum No. 51, Table 111, page 146, March, 1943.

TABLE 62

HOSPITAL ADMISSION RATES DURING YEAR FOR CASES CLASSIFIED BY DAYS OF HOSPITAL STAY, AND THE ANNUAL DAYS OF HOSPITAL CARE RESULTING FROM CASES CONTRIBUTING A SPECIFIED NUMBER OF DAYS (t) OR LESS - 8,758 CANVASSED WHITE FAMILIES IN 18 STATES DURING 12 CONSECUTIVE MONTHS, 1928-31

Hospital Days (t)	Number admitted for Specified Number of Hospital Days (t)	Percent of Those Admitted with Specified Number of Hospital Days (t)	Cumulated Percent
1	548	23.41	
2	208	8.89	32.30
3	101	4.31	36.61
4	96	4.10	40.71
5	70	2.99	43.70
6	55	2.35	46.05
7	89	3.80	49.85
8	60	2.56	52.41
9	55	2.35	54.76
10	192	8.20	62.96
11	62	2.65	65.61
12	106	4.53	70.14
13	46	1.97	72.11
14	182	7.77	79.88
15	35	1.50	81.38
16	24	1.03	82.41
17	20	.85	83.26
18	21	.90	84.16
19	14	.60	84.76
20	12	.51	85.27
21	64	2.73	88.00
22	11	.47	88.47
23	6	.26	88.73
24	13	.55	89.28
25	6	.26	89.54
26	6	.26	89.80
27	8	.34	90.14
28	30	1.28	91.42
29	7	.30	91.72
30	20	.85	92.57
31 or over	174	7.43	100.00
Total	2,341	100.00	100.00

SOURCE: Public Health Reports, Vol. 57, #38, September 18, 1942. Selwyn D. Collins.

TABLE 63

HOSPITAL DISCHARGES BY LENGTH OF STAY

Length of Stay	Discharges	
	Number	Percent
1 - 7 days	217,818	37.8
8 - 14 days	201,380	34.9
15 - 30 days	104,781	18.2
	523,978	90.9
Over 30 days	52,113	9.1
Total	576,092[1/]	100.0

1/ Excludes 524 discharges from institutions for the chronically ill and 7 discharges for whom the length of stay was unreported.

SOURCE: Hospital Discharges Study, Deardorff & Fraenkel, New York City, 1933.

TABLE 64

AVERAGE STAY IN HOSPITALS BLUE CROSS HOSPITAL SERVICE PLANS, 1943

Year	Average Stay in Hospitals for All Plans
1940	8.1 days
1941	7.6 days
1942	7.8 days
1943	7.83 days

SOURCE: Report, Hospital Service Plan Commission, American Hospital Association, page 55.

TABLE 65

AVERAGE LENGTH OF STAY GENERAL AND SPECIAL HOSPITALS

Number of Hospitals Reporting	Average Days
4,270	9.59

SOURCE: Ray Hudenburg, Hospitals, 20:52 October, 1946

TABLE 66

AVERAGE LENGTH OF STAY, GENERAL AND ALLIED SPECIAL HOSPITALS TERRITORY OF HAWAII, BY ISLANDS AND OWNERSHIP OF HOSPITALS, 1945

Island and Ownership	Average Length of Stay
Oahu	
Non-profit hosp.	8.3
Prop., Individual	6.3.
Prop., Corporate	7.1
Total - Oahu	8.1
Hawaii	
Prop., Individual	10.3
Prop., Corporate	9.4
Government	10.2
Total - Hawaii	9.9
Kauai	
Non-profit	8.8
Prop., Individual	5.4
Prop., Corporate	9.6
Total - Kauai	8.8
Maui	
Prop., Corporate	9.5
Government	8.5
Total - Maui	9.1
Lanai	
Prop., Corp.	4.6
Molokai	
Non-profit	7.0
Prop., Corporate	4.0
Total - Molokai	6.0
Total Territory	8.5

SOURCE: Hospital Service Study Commission, Hospital Survey, 1946.

EXHIBIT "A"

DIGEST AND SUMMARY
OF
SURVEYS, POLLS, OPINIONS ON COMPULSORY INSURANCE (Federal)

Of the 15 polls recorded on the table which follows, only 6 gave the actual numbers of people interviewed. These six represented members of medical societies, a partial poll of Congress (just before the Christmas recess of 1945) and cross-sections of the general population.

The totals of these several reportings yield the following data:

12,052	Total number interviewed (or returning ballots)	100%
4,754	Reported in favor of compulsory insurance	39%
Of which		
5,536	Reported against compulsory insurance	46%
1,759	Either undecided or unqualified to vote	15%

Of the remaining nine polls, one, the Gallup Poll, reported 37% of general public questioned had never heard of or read about the Wagner-Murray-Dingell bill. The same survey reported that the college educated had a better index, with 67% having heard of or read about the bill. This same survey questioned the people relative to the quality of service they would expect if the government handled the insurance program: 32% expected better care; 23% the same quality; 35% not as good, while 10% had no opinion.

A second survey of the remaining nine polls, conducted by Knight and Parker, asked the general public in California to indicate whether they would go to their own private doctor in case of sickness, surgery or accident or to the state plan doctor, if they were compelled to join a state-operated hospital and medical service plan; 73.7% chose their private doctor, 26.1% state doctor, and .2% do not believe in doctors. Of the 26.1% preferring a state doctor, 20.2% favored the plan, though 1.5% would be deducted from their pay checks; 1.9% were unfavorable to the deduction; 4% did not know. Of this same 26.1%, when questioned as to choice between voluntary and compulsory membership in a state plan, 15.9% voted for voluntary, 9% for compulsory, with 1.2% not knowing which they would prefer.

The other seven reporting no numbers interviewed, covered doctors, dentists, editors, experts in public health work and general public. The percentages in favor of compulsory insurance ranged from 20% to 86%, with four either 50% or above.

SURVEY, POLLS, OPINIONS
ON
COMPULSORY INSURANCE (Federal)

Exhibit A
(cont'd)

Conductor of Poll	Whom Interviewed	Questions Asked	Results in %		Source
			Yes or For	No or Against	
Academy of Medicine (Cincinnati, Ohio)	All members*	whether in favor or not	5	95	Cincinnati J. of Med. 27:250 April, 1946
American Press (a trade monthly)	editors	Do you favor a system of medical care & hosp. ins.?	20	80	Medical Economics 23:130 Dec., 1945
Associated Press, Frank Carey	partial poll of Congress*	Do you favor Pres. Truman's proposal for a nat'l prepaid health ins. plan financed by additional soc. security taxes & by general gov't revenues?	30	51	Ann Arbor News 112:12 1-14-46
Bureau of Applied Research, Columbia Univ., by Arthur Kornhauser	Physicians & experts in public health work	supported Pres. Truman's recommendation that Congress est. a system of comp. health ins. in Soc. Sec. setup	60	40	PM 6:6 (appearing in American Mag. Jan., 1946)
Des Moines Register (Iowa)	citizens of state	On Pres. Truman's comp. health ins. plan, do you think Congress should pass such a law?	40	49	J. of Iowa State Med. Soc. 36:61 2-46
N. Y. State Comm. on Med. Care.	people of N. Y. State	Do you think everybody in N. Y. State should have ins. to pay doc. & hospital bills?	86	14(?)	Survey Graphic 35:85 3-46

Surveys, Polls, Opinions on Compulsory Insurance (Federal)

Exhibit A
(cont'd)

Conductor of Poll	Whom Interviewed	Questions Asked	Results in %		Source
			Yes or For	No or Against	
Opinion Res. Corp. Dr. Claude Robinson	public opinion	Survey on favoring a comp. health ins. plan, prefer to pay in advance, believe it good for nation	34	66(?)	C.I.O. News (Mich.) 8:7 12-7-45 Medical Economics 23:67 1-46
Pierre Fauchard Acad. Poll Panel	dentists	If any form of gov't. controlled or subsidize health prog. is adopted, would the omission of dent. from it be injurious to the prof.?	50.5	48.0	Dental Survey 20:1803 10-45
Washington Post	residents of Wash.	The pres. has suggested that a small amt. be paid from a worker's wages into an ins. fund that would help pay doctor, dentist & hosp. bills for the worker & his family. Do you approve or disapprove of the plan?	70	21	Medical Annals of D. C. 15:135 3-46
Wayne Co. Med. Soc. (Mich.)	members of Wayne Co. Med. Soc.	Are you in favor of the W.M.D. bill? Are you a gen. pract.? Have you at any time serve in Med. Corps of U. S. Army For.? In what Cong. Dist. do you vote?	2.6	97.1	Detroit Med. News 37:6 3-18-46

Surveys, Polls, Opinions on Compulsory Insurance (Federal)

Exhibit A
(cont'd)

Conductor of Poll	Whom Interviewed	Questions Asked	Results in %		Source
			Yes or For	No or Against	
Gallup Poll By Geo. Gallup for Am. Inst. of Pub. Op.	general public (with college ed.)	Have you heard or read about the W.M.D. health ins. bill which requires weekly pay ded. from every worker & emp. for med., dent. hosp. ins.?	37 66	63 34	Detroit News 73:6 5-19-46
		If the government handled a health ins. prog. do you think you would get better medical care or not as good medical care as you are now getting?	better 32 same 23 not as good 35 no opinion 10		
Comm. Rel. Committee of the Woonsocket, R. I. Hosp.	lay public*	Would you favor comp. ins. to cover the cost of hospital care as a sub. for vol. plans which meet the same purp.? If you were a hosp. trustee of Woonsocket Hosp. & knew that a large sum of money was needed from what source would you seek fund?	38	62	Rhode Island Med. J. 28:815 11-45

Surveys, Polls, Opinions on Compulsory Insurance (Federal)

Exhibit A
(cont'd)

Conductor of Poll	Whom Interviewed	Questions Asked	Results in %		Source
			Yes or For	No or Against	
Successful Farmer (Public)	farm group	What do you think should be done, if anything to prov. for payment of doc., dent. and hospital bills for people in this country?	56	37	Michigan Medical J. 45:1310 10-46
Foote, Cone & Belding (Res. Dept. Chicago)	rep. cross-* section of pop. of the state of Michigan during June & July, 1944	Do you think we should have some sort of a gov't oper. med-hosp. plan?	38.7	42.8	Public Relations of the Medical Profession State of Michigan for Michigan Health Council Report
Calif. Assoc. Knight & Parker	Pop. of State of California	If you were compelled to join a state operated hosp. & med. serv. plan would you go to the state plan doc. or to your own private doc. in case of sickness, surgery or accident?	Pri. doc. 73.7 St. doc. 26.1 No belief in docs. .2		Report of Public Opinion Survey made expressly for Calif. Med. Assoc. March, 1945 Calif. Asso. of Knight & Parker
Foote, Cone Belding	Pop. of* State of Calif. (Rep. cross-section of 7,000,000 citizens of state)	Poll covering: Why citizens think we should have fed. or socialized med.	50	34	Interpretive Report to the Council of the Calif. Med. Assoc. made during month of Nov., 1943, submitted to the Council of C. M. A. 1-23-44 by Mr. Jno. R. Little

*Total number interviewed recorded.

EXHIBIT "B"

HOSPITAL REIMBURSEMENT FORMULA FOR EMIC.

U. S. Department of Labor
Children's Bureau
and
Federal Security Agency
Office of Vocational Rehabilitation
and
Veterans Administration
Department of Medicine and Surgery

Joint Hospital Form 1
July 1945

HOSPITAL STATEMENT OF REIMBURSABLE COST

Name of Hospital 1/ _____

Address _____

Period covered by statement: From _____, 194___, to _____, 194___

A. TYPE OF CONTROL 2/ (check one only)

Government		Nonprofit organizations	Proprietary
☐ State	☐ City	☐ Church related --- Catholic	☐ Individual or partnership
☐ County	☐ City-County	☐ Church related --- Other	
		☐ Nonprofit Associations	☐ Corporation

B. STATISTICAL DATA

In-patient statistics:

1. Beds (exclusive of bassinets) available at beginning of account year.. _____
2. Beds (excl. of bassinets) available at end of account year ..... _____
3. Bed-days 3/ ..... _____
4. Total in-patient days (excl. of newborn-infant days 4/ ..... _____
   (a) In rooms with only 1 bed ..... _____
   (b) In rooms with 2 or more beds ..... _____
5. Percent of in-patient days in rooms with 2 or more beds (item 4 (b) divided by item 4) ..... _____
6. Percent occupancy (total in-patient days, item 4, divided by bed-days, item 3) ..... _____
7. Discharges (including deaths) ..... _____
8. Average length of stay (in-patient days, item 4, divided by discharges, discharges, item 7) ..... _____

Out-patient statistics:

9. Total out-patient visits 5/ provided during account year (sum of items 10, 11, 12 below) ..,..... _____
10. Visits by clinic patients ..... _____
    (a) Clinic visits ..... _____
    (b) Visits for special services (laboratory, X-ray, etc.)..... _____
11. Visits to emergency service ..... _____
12. Visits by private patients (laboratory, X-ray, etc.) ..... _____

NOTE: For any terms not defined here, see the manual "Hospital Accounting and Statistics" of the American Hospital Association.

1/ Hospitals, as the term is used in this Statement, include maternity homes providing delivery service and convalescent homes.

2/ Type of control indicates ownership or auspices under which the institution is conducted.

3/ Bed-days should be the currently compiled count of beds available each day, or if this is not possible, the bed complement at the end of the report year multiplied by 365 days.

4/ Newborn-infant days to be excluded from the count of total in-patient days are only those days when an infant occupies a bassinet (in the nursery) during the mother's hospitalization. Thus, the count of days for a prematurely born infant remaining in the hospital after the mother is discharged, or for an infant delivered at home and later admitted to the hospital, or for an infant admitted or transferred out of the nursery for an illness is included in the total in-patient days reported.

5/ Out-patient visits for the purpose of this statement are the occasion of any personal, professional services to an out-patient (an individual registered for and receiving service in the institution but not occupying a regular hospital bed or bassinet) on any single admission in any subdivision of an out-patient department, clinic, or hospital. This count includes visits of individuals (including private service patients) who are not admitted to in-patient service but who receive care in emergency rooms, or X-ray, laboratory, physical therapy, and similar services.

If an individual receives services in more than one subdivision of an out-patient department, or in other service divisions of a hospital or clinic, a visit should be recorded for each separate service, for instance:

A patient served at a medical clinic, referred to the surgical clinic, to the X-ray department for examination, and also to the physical-therapy service for treatment, would have four visits recorded. Also, a private patient referred to the X-ray and laboratory services for examinations would have two visits recorded.

Note that visits of private out-patients are included, for the purposes of this statement, in the count of out-patient visits.

C. TOTAL OPERATING EXPENSES

1. Total amount of expenses per book [6] ..... _____
2. Expenses to be deducted [7] (if included in item 1 above) ..... _____
   (a) Research expense and medical education ..... _____
   (b) Cost of gift shops, lunch counter, etc. ..... _____
   (c) Cost of guest meals or meals paid for employees ..... _____
   (d) Cost of telephone and telegraph charges paid for by patients, guests or employees ..... _____
   (e) Cost of drugs or supplies that are purchased by individuals not admitted as in-patients or out-patients ..... _____
   (f) Provision for depreciation of buildings and equipment ..... _____
   (g) Bad debts or provision therefor ..... _____
   (h) Estimated value of donated or voluntary services [8] ..... _____
   (i) Interest expense ..... _____
   (j) Real estate taxes and income taxes ..... _____
   (k) Rent expense ..... _____
   (m) Other [9] (specify) ..... _____
   _____
   (n) Total of items (a) through (m) ..... _____
3. Total amount of operating expenses applicable to in-patient and out-patient services (item C-1 minus item C-2 (n) ..... _____

D. OPERATING EXPENSES FOR CALCULATING REIMBURSABLE COSTS [10]

Classification of Expenses	Total	In-Patient Service	Out-Patient Service [11]		
			Total-Clinic and Private	Clinic	Private
1. Administration					
2. Dietary					
3. Laundry					
4. Housekeeping					
5. Heat, light, power, and water .					
6. Maintenance and repairs					
7. Motor service					
8. Medical and surgical service ..					
9. Nursing service and nursing education					
10. Medical records and library ...					
11. Social service					
12. X-ray [12]					
13. Laboratories [12]					
14. Pharmacy					
15. Physical therapy [12]					
16. Other special services [13] ..... (specify) _____ _____					
17. Total					

NOTE:

6/ The amount to be entered should be as follows:

If reporting on the-----	Amount to be entered:
Accrual basis.....	Total expenses.
Cash basis.....	Total cash disbursements
Modified cash basis.....	Total cash disbursements after giving effect to adjustments.

Do not include in item C-1 expenditures for land, buildings, and permanent improvements and equipment, whether replacements or additions.

7/ If the public accountant certified that the "total amount of expenses" (C-1) did not include any of the items listed under item C-2, entries should be made for items C-1 and C-3 only.

8/ Any estimated value for the services of sisters or other members of religious orders who serve in the hospital are to be included in this item.

9/ Among the types of expenses included in item C-2 (m) that are to be deducted will be those for services furnished not by the hospital's own personnel but by other persons for whom the hospital acts as a billing and collection agency. X-ray, laboratory, and physical-therapy services are sometimes provided in this manner. Fuller explanation is made in foot note 12, which discusses the distinction between items D-12, D-13, D-15, and C-2 (b).

10/ The expenses for all services provided by the hospital to all patients are to be included in this section.

A hospital having fewer than 25 available beds may elect to submit a statement of operating expenses in accordance with the classification per books of the hospital instead of using the classification of expenses given in section D. Such a hospital should, however, complete all items in sections A, B, and C.

Maintenance of student nurses and members of religious orders who serve in the hospital may be included in the appropriate departmental items 1 through 15.

Detailed instructions of expenses to be included under each heading and a method for allocating in-patient and out-patient operating expenses are given in the manual, "Hospital Accounting and Statistics," of the American Hospital Association.

11/ Columns 4, 5, and 6 should cover all expenses incurred in rendering service to out-patients (as defined in footnote 5) as differentiated from in-patients.

Hospitals that provide out-patient services both to clinic out-patients and to private out-patients may at their own option distribute their total out-patient expenses between these two types of out-patient care. If this is done, columns 4, 5, and 6 should be used. If the hospital does not wish to distribute the out-patient expenses, only column 4 should be used.

Hospitals that furnish out-patient services to clinic patients only should fill in column 5.

Hospitals without organized out-patient clinics, that furnish services to private out-patients only, should fill in column 6.

If in-patient and out-patient expenses cannot be segregated according to the method advocated by the American Hospital Association or by a comparable method, estimated expenses to be entered in item 17 may be computed as follows:

For hospitals that do not separate expenses but do furnish services to both clinic and private out-patients:------

Multiply the total number of out-patient visits (B-9) by $1.50 and enter the result in item 17, column 4.

For hospitals that furnish services to clinic out-patients only:----

Multiply the number of visits of clinic patients (B-10 plus B-11) by $1.50 and enter the result in item 17, column 5.

For hospitals that furnish services to private out-patients only:----

Multiply the sum of the number of visits to emergency services and visits by private patients (B-11 plus B-12) by $1.50 and enter the result in item 17, column 6.

12/ If the hospital provides all X-ray services, including the professional services of a radiologist, all expenses are to be included here. (This refers to any individuals who receive salaries, fees, commissions, or maintenance).

If the hospital provides X-ray services exclusive of the professional services of a radiologist, only the expenses to the hospital should be included in this item. (The radiologist may bill separately for his professional services).

If the X-ray department of a hospital is rented outright to a radiologist, any expenses recorded in the hospital's books are to be excluded from this item and should be shown in item C-2 (m).

If the hospital acts as the billing and collection agency for radiologists or other individuals not employed by the hospital who provide service in this department, the amounts collected for, and paid to, these individuals should be excluded from this item and should be shown in item C-2 (m) if recorded in the hospital's books.

These instructions should be followed in determining cost for laboratory or physical-therapy service.

13/ List each special service not elsewhere included, such as cardiography, basal metabolism, and special expenses such as salary and maintenance of chaplain or maintenance of chapel.

E. CALCULATION OF REIMBURSABLE COST OF IN-PATIENT SERVICE

1. Total amount of operating expenses for in-patient service (from item D-17, column 3) .....
2. Less: Income from Federal or State public health agencies for nursing education, including income for maintenance, uniforms, supplies, etc. 14/.....
3. Balance (E-1 minus E-2).....
4. Number of in-patient days (item B-4).....
5. Average computed per diem reimbursable cost (E-3 divided by E-4).....
6. Supplementary allowance for depreciation of buildings and equipment, rent, interest, etc. (10 percent of item E-5).....
7. Total (E-5 plus E-6).....
8. Reimbursable cost of in-patient service per patient day 15/ (85 percent of E-7, unless more than 70 percent of all in-patient days are in rooms with 2 or more beds (B-5 16/.....

F. CALCULATION OF REIMBURSABLE COST OF OUT-PATIENT VISIT 17/

ITEM	Total Clinic and Private	Clinic	Private
1. Total operating expenses (item D-17) 18/			
2. Number of out-patient visits 19/			
3. Average cost per visit (F-1 divided by F-2)			
4. Supplementary allowance for depreciation of buildings and equipment, rent, interest, etc. (10 percent of item F-3)			
5. Reimbursable cost per visit (F-3 plus F-4) 20/			

14/ The amount chargeable to Federal or State public health agencies during the accounting year covered by the statement should be entered, not the amount of cash received.

15/ Subject to the maximum rate established by the State agency.

16/ Percent of in-patient days in rooms with two or more beds to total in-patient days in all accommodations (excluding new-born-infant days) (Item B-5)		Percent to be used in computing reimbursable cost of in-patient service per patient day. (Item E-8)
More than	Not more than	Percent
98	100	100
96	98	99
94	96	98
92	94	97
90	92	96
88	90	95
86	88	94
84	86	93
82	84	92
80	82	91
78	80	90
76	78	89
74	76	88
72	74	87
70	72	86
0	70	85

17/ The columns in which entries are to be made in this section will depend on whether organized clinic out-patient services are provided and whether the expenses for such services are separated from private out-patient services. See Footnote 11/

18/ If the entry in item D-17 is in column 4, enter the same figure in column 2 of item F-1; if the entry in item D-17 is in column 5, enter the same figure in column 3 of item F-1; if the entry in D-17 is in column 6, enter the same figure in column 4 of item F-1. If all three columns are filled in for item D-17, the same figures should be used in the three columns of item F-1.

19/ The number of out-patient visits used here will depend on the entries in item F-1. If column 2 is used, the number of out-patient visits should be item B-9; if column 3 is used, the number of visits should be item B-10 plus B-11; if column 4 is used, the number of visits should be the sum of B-11 and B-12.

20/ Subject to the maximum rate established by the State agency.

G. FORM OF CERTIFICATION BY OFFICER OF HOSPITAL 21/

I, _____, _____ of
(Name) (Title)

the _____, _____, _____
(Name of Hospital) (City) (State)

do certify that I have examined the accompanying statement of total expenses, the allocation thereof between in-patient and out-patient services, and the calculation of reimbursable cost of in-patient service per patient day and of out-patient service per visit for the hospital for the year ended _____, 194____, and that to the best of my knowledge and belief it is a true and correct statement prepared from the books and records of the hospital in accordance with instructions issued by the Children's Bureau, United States Department of Labor, and Office of Vocational Rehabilitation, Federal Security Agency, Washington, D. C., under date of July 1945 (except as indicated below) as contained in this Statement.

A certification by a public accountant of the correctness of the amount entered in item C-1 (is) (is not) attached.

*I CERTIFY that the hospital could not obtain the services of a public accountant to make an audit to determine the total expenses of the hospital during the year.

I FURTHER CERTIFY that the records of the hospital for the period covered by the operating statement were maintained on the_____basis.
(Accrual, cash, or modified cash)

(Signed)_____
Officer or Superintendent of hospital

_____
(Title)

*Delete this sentence if certification by public accountant is attached.

21/ The statement of expenses should be based upon the amount of total expenses certified to by a public accountant who is not an employee of the hospital.

This form is to be executed by every hospital. A hospital operated by city, county, or State government may furnish certification by the superintendent or an officer of the hospital. For form to be used by public accountants, see below.

H. FORM OF CERTIFICATION BY PUBLIC ACCOUNTANT

I HEREBY CERTIFY that the amount $_____shown in item C-1 of the accompanying statement of total expenses of_____, _____,
(Name of Hospital) (city)
_____for the year ended_____, 194___, is correct in
(state)
accordance with my audit of the books and records of the hospital after giving effect to all adjustments resulting from my examination of the books of the hospital, and to the instructions outlined by the Children's Bureau and Office of Vocational Rehabilitation for preparation of Statement of Reimbursable Cost under date of July 1945.

My examination was made in accordance with generally accepted auditing standards applicable in the circumstances and it included all procedures that I consider necessary (except as qualified below).

The amount entered in item C-1 (includes) (excludes) items listed under item C-2.

The records of the hospital for the period covered by the operating statement were maintained on the_____basis.
(Accrual, cash, or modified cash)

_____
(Signature of public accountant)

The following revision of the Emic formula was recommended at the meeting of the American Hospital Association on September 30 through October 4, 1946:

1. Hospitals shall be permitted to submit calculations each six months.

2. Elimination of the 15 percent differentials between private accommodations and ward care.

3. Instead of 10 percent supplementary allowance for depreciation of buildings and equipment, actual depreciation on facilities shall be allowed.

4. The inclusion of taxes in the reimbursable costs.

5. The inclusion of pension and annuity expenses for hospital employees.

6. Payments to religious organizations for services of members shall be included, provided that such payments do not exceed amounts paid in the community for comparable services.

7. The provision of care in "multi-bed" accommodations not exceeding 8 beds, and in single rooms when medically indicated.

EXHIBIT "C"

DIGEST OF THE TITLE II OF "NATIONAL HEALTH ACT" (S. 1606 and H. R. 4730)

TITLE I provides for an expansion of federal-state cooperative health programs dealing with: 1) General public health work, 2) Maternal and child health services, 3) Services for crippled children, 4) Medical care for needy persons.

SUMMARY OF MAIN PROVISIONS OF
TITLE II - PREPAID PERSONAL HEALTH SERVICE BENEFITS

Persons Entitled to Receive Personal Health Service Benefits

This title proposes to make available personal health service benefits to the following:

1. Individuals who are currently insured and determined by the Social Security Board to be eligible in a current benefit year.

   An individual is currently insured for a benefit year if he earned in covered employment (see last page of this digest), either (a) $150 or more during a 1-yr. period of (b) at least $50 in each of at least 6 calendar quarters during a 3-year period preceding the benefit year by an interval of 6 months (in order to give the Social Security Board time to compile the necessary wage records). Any quarter in which the individual has been under a disability which lasted at least 6 consecutive months is to be excluded from the 3-year period and the period extended back an equal length of time.

2. Dependents of individuals who are currently insured; dependents include: an unmarried child (including a stepchild, adopted or foster child) under the age of 18, or a child of any age who is under a disability which has lasted at least 6 consecutive months and is living with the individual or receiving regular support from him; a wife who is living with the individual or receiving regular support from him; and a husband disabled at least 6 consecutive months or a parent, living with or receiving regular and substantial support from the individual.

3. Persons entitled to receive monthly old-age or survivor benefits under the Social Security Act.

4. Any other person on whose behalf equitable reimbursements have been made to the Personal Health Service Account by a federal, state or local public agency, including needy persons entitled to medical care under the federal-state program for medical care of needy persons also established by this bill.

5. No individual is entitled to receive personal health service benefits with respect to any injury, disease or disability for which he could receive similar care under a workmen's compensation plan. However, a workmen's compensation agency may arrange to have personal health services furnished through the health insurance system for such injuries or disabilities by making equitable reimbursements to the Personal Health Services Account.

Personal Health Service Benefits Furnished

The following benefits are to be provided beginning April 1, 1947:

General Medical Benefit: This term means all necessary services furnished by a physician engaged in the general or family practice of medicine, at the office, home, hospital or elsewhere, and including preventive, diagnostic and therapeutic care, and periodic physical examination.

Special Medical Benefit: This term means necessary services requiring special skill or experience and furnished at the office, home, hospital or elsewhere.

General and Special Dental Benefit: This term means all necessary dental services including preventive, diagnostic and therapeutic treatment, care and advice and periodic examinations by a dentist engaged in general practice and dental services requiring special experience furnished at the office, hospital or elsewhere. However, if the Surgeon General, after consultation with the National Advisory Medical Policy Council, and with the approval of the Federal Security Administrator, finds that the number of dentists available is inadequate, he may limit the content of general and special dental benefits for a specified period, provided that after July 1, 1947, the restricted content must include at least:

a. an examination (including x-ray) and diagnosis,

b. prophylaxis,

c. extraction of teeth considered by the dentist and an attendant physician as injurious to the general health of the patient and

d. treatment of acute diseases of the teeth and adjacent parts, including fracture of the teeth or jaws.

The restriction on content may be made to apply only above a specified age. Any restriction on content which is imposed is to be reduced or withdrawn as rapidly as practical.

Home Nursing Benefit: This term means nursing care furnished in the home by a registered nurse; or by a practical nurse who is legally qualified by a state or (in the absence of such standards) meets standards established by the Surgeon General and who furnishes services under the direction or supervision of a state or local health agency or of a nursing organization supplying or supervising registered nurses. However, if the Surgeon General after consultation with the Advisory Council, and with the approval of the Federal Security Administrator, finds that the number of available nurses is inadequate, he may restrict the content of home-nursing benefits by limiting it to part-time care on an hourly or visit basis, to specified types of cases, to a maximum amount of service per case, or otherwise as may be practical and necessary. Any such restriction shall be reduced or withdrawn as rapidly as practical.

Laboratory Benefit: This term means necessary laboratory or related services, supplies or commodities, including chemical, bacteriological, pathological, diagnostic and therapeutic x-ray, and related laboratory services, refractions and other services furnished by a physician or optometrist, physiotherapy, special appliances prescribed by a physician and eye-glasses prescribed by a physician or other legally qualified practitioner. However, if the amount in the Personal Health Services Account requires, the Surgeon General may, after consultation with the Advisory Council, limit the laboratory benefits payable either with respect to a class of services, supplies or commodities, with respect to a maximum payments for a beneficiary in a benefit year, with respect to a specified fraction of the cost or by combinations of such restrictions.

Hospitalization Benefit: This term means - up to 60 days of hospitalization in a benefit year, provided that if moneys in the Personal Health Services Account are adequate, the Surgeon General may increase the maximum to not more than 120 days for the following year. No hospitalization benefit is payable more than 30 days following the diagnosis of tuberculosis or a psychosis, or for care in a hospital or other institution for mental or nervous disease or tuberculosis.

Limitation: If necessary to reduce or prevent abuses of entitlement to benefit, the Surgeon General may, after consultation with the Advisory Council, and with the approval of the Federal Security Administrator, permit individuals receiving general medical, general dental or home-nursing benefit to be required to pay a fee for the first or for each service in a period of sickness or course of treatment. The maximum size of the fee shall be such as not to interpose a substantial financial barrier against proper and needed receipt of care. The fee may apply only to home calls, only to office visits or to both, and a maximum may be fixed for the total fee payments that may be charged in a period of sickness; the fee or total fee payments may differ for urban and rural areas or among states and communities. Any such permission for charging fee payments shall be withdrawn as rapidly as practical.

Administration

Federal Administration: The Surgeon General of the Public Health Service, under the supervision and direction of the Federal Security Administrator, is made responsible for administering the

prepaid personal health service benefits program and arranging for the availability of the benefits to be provided, after consultation with the National Advisory Medical Policy Council as to questions of general policy and administration. In consultation with the Social Security Board, he also has the duty of studying and making recommendations as to the most effective methods of providing personal health service benefits and other problems concerning health and related matters.

Agreements with State and Local Departments; In administering the program, the Surgeon General is directed to give priority and preference to utilizing the facilities and services of state and local departments or agencies on the basis of mutual agreements with such agencies.

Local Advisory Committees: For states and local areas where such arrangements are not made, the Surgeon General is to appoint local advisory committees, with professional and public representatives, to aid in the administration of the program. These committees are to be consulted at frequent intervals, and are authorized to make annual and special reports, with recommendations, to the Surgeon General. Similar committees, with corresponding functions, must be appointed by each state or local agency which agrees to cooperate in the administration of the program.

Rules and Regulations: After consultation with the Advisory Council and with the approval of the Federal Security Administrator, the Surgeon General is to prescribe and publish rules and regulations not inconsistent with other provisions of the act and necessary to efficient administration - with the further proviso that rules and regulations relating to performance by federal, state or local agencies, cooperating under mutual agreements, or to the establishment of local areas for administrative purposes, shall be made only after consultation with such agencies.

Agreements: The Surgeon General is authorized to negotiate agreements:

a. to use and to pay fair compensation for the services and facilities of public and private agencies, and of private persons or groups of persons,

b. for the purchase or availability of supplies and commodities necessary for benefits and,

c. for the Personal Health Services Account to receive reimbursements for services rendered to non-insured individuals.

Coordination: The Surgeon General is directed to enter into agreements or cooperative working arrangements with the Chief of the Children's Bureau and with the Social Security Board to ensure coordination in the administration of the prepaid personal health service benefits program and the other programs established by the bill.

Reports to Congress: The Surgeon General is to make a full report to Congress, at the beginning of each regular session, on his administration of the program. This report must include a record of his consultations with the Advisory Council, its recommendations, and his comments thereon.

Appeals: Appeal bodies are to be established by the Surgeon General to hear complaints from individuals entitled to benefit, from practitioners who have agreed to furnish services, and from participating hospitals. Where appropriate, steps are to be taken to remedy the grounds of complaint. Appeal bodies are also to be established to hear and determine disputes among practitioners and/or participating hospitals. Where the dispute involves questions of professional practice or conduct, the appeal body shall include competent and disinterested professional persons; where the dispute involves only questions of professional practice or conduct, the hearing body shall consist only of professional persons.

In administering these appeals provisions, the Surgeon General is to have all the applicable powers and duties conferred on the Social Security Board by section 204, 205 and 206 of the Social Security Act (relating to powers to subpoena witnesses, obtain evidence, etc.). Such powers and duties are to be subject to the limitations and rights of judicial review also contained in Sec. 205 of the Social Security Act.

Eligibility of Individuals: The Social Security Board is to make decisions as to the eligibility rights of individuals applying for personal health service benefits; in carrying out this responsibility it is to have all the powers and duties conferred on it by title II of the Social Security Act, subject to the same limitations and rights of judicial review.

National Advisory Medical Policy Council

Membership: A National Advisory Medical Policy Council is established, consisting of the Surgeon General as chairman and 16 members appointed by him with the approval of the Federal Security Administrator. The membership shall include medical and other professional representatives, and public representatives, selected from panels of names submitted by the appropriate professional organizations and by persons or organizations informed on the need for or provision of medical, dental, nursing, hospital, laboratory, or related services and benefits.

Meetings: The Advisory Council shall meet at least twice a year and whenever at least 4 members request a meeting. The regular terms of office for appointed members is four years. Members are to receive travel expenses and not more than $25 per day for time devoted to the official business of the Council, and shall be provided with such secretarial or other assistants as Congress shall authorize each year.

Duties: The Advisory Council is to advise the Surgeon General as to general policy and administration, including professional standards of quality to apply to personal health service benefits, designation of specialists, methods to stimulate high standards through coordination of services, standards for participating hospitals, adequate and suitable methods of paying for benefits, studies and surveys of personal health services and grants-in-aid for professional education and research projects.

Special Local Committees: The Advisory Council is to establish special technical, regional or local committees to advise on general or special questions, professional and technical subjects, administration, problems affecting regions or localities and related matters.

Policies for Administration

Eligible Practitioners: All legally qualified physicians, dentists and nurses, or groups of physicians, dentists or nurses whose members are legally qualified by a state, are entitled to furnish benefits under the program.

Free Choice: Every individual shall have free choice of the doctor or dentist or group of doctors or dentists - from among those participating in the program and subject to the consent of the doctor or group - from whom he shall receive general medical or dental care, and the right to change his selection.

Specialists: Specialist services, to be paid for at special rates, and practitioners qualified to receive such special rates of payment for designated services, shall be determined by the Surgeon General on the basis of general standards prescribed after consultation with the Advisory Council. Such standards are to utilize as far as possible standards and certifications developed by competent professional agencies and to take into account the personnel resources and needs of regions and local areas.

Availability of Specialist and Home-nursing Services: The services of specialists and consultants shall ordinarily be available only on the advice of the family practitioner or an attending specialist or consultant; home-nursing services shall ordinarily be available only on the advice of an attending physician; but such services may also be available when requested by the individual and approved by a medical officer appointed by the Surgeon General.

Lists of Practitioners: The Surgeon General is to publish and otherwise make known in each local area the names and specialties of all medical and dental practitioners and groups of practitioners who have agreed to furnish services under the program.

Method of Administration: Methods of administration, including methods of making payments to practitioners, shall:

1. Insure prompt and efficient care of individuals entitled to benefits.

2. Promote personal relations between physician and patient.

3. Provide professional and financial incentives for the professional advancement of practitioners, and encourage high standards in the quality of services furnished as benefits, through

adequacy of payments to practitioners, assistance in their use of opportunities for postgraduate study, and coordination among the several services furnished, between preventive and curative services, and otherwise.

4. Aid in the prevention of disease, disability and premature death.

5. Ensure the provision of adequate service with the greatest economy consistent with high standards of quality.

Limitation of Number of Patients: In order to maintain high standards of quality, the Surgeon General may prescribe maximum limits to the number of potential beneficiaries for whom a practitioner or group of practitioners may undertake to furnish general medical or dental services. Such limits may be nationally uniform or adapted to take account of relevant factors.

Collective Responsibility of Practitioners: In each local Area the provision of general medical or Dental benefits to all individuals entitled thereto shall be a collective responsibility of the practitioners in the area who have undertaken to furnish such benefits.

Methods of Payment to General Practitioners (Physicians and Dentists)

Choice of Methods: Payments to general practitioners (physicians and dentists) shall be made according to the method chosen by the majority of such physicians or dentists in each local area from among the following methods:

1. Fees for services rendered to individuals, according to a fee schedule.

2. On a per capita basis, according to the number of individuals entitled to benefit who are on a practitioner's list.

3. On a salary basis, whole time or part-time.

4. On a combination or modification of these bases, as the Surgeon General may approve.

However, the Surgeon General may make payments by another method (among the methods listed) to those doctors who do not prefer the method chosen by the majority. Any of the methods listed may also be used in making payments to groups of practitioners which include specialists as well as general practitioners.

Specialists: Payments to specialists and consultants may be on a salary basis (whole or part-time), per session, fee-for-service, per capita or other basis as the Surgeon General and the specialists and consultants may agree.

Payment Rates: Rates of payment for particular services may be nationally uniform or adapted to take account of relevant regional or local conditions and other factors. Payments are to be adequate, especially in terms of annual income or its equivalent and by reference to annual income customarily received among physicians, dentists or nurses, having regard for age, specialization and type of community; and payments are to be commensurate with skill, experience and the responsibility involved in furnishing the service.

In any local area where payments for general practitioners are made solely on a per capita basis, per capita payments shall be made on a pro rata basis to the participating practitioners with respect to any individuals in the area who after due notice have failed to select a general practitioner or having made one or more selections have been refused.

Participating Hospitals and Methods of Payment to Hospitals

Participating Hospitals: A participating hospital is an institution providing all necessary and customary hospital services and found by the Surgeon General to meet reasonable standards of hospital care and to have procedures for making necessary reports to assure that hospitalization bene-

fits will be provided only to persons entitled to them. The Surgeon General may accredit a hospital for limited varieties of cases or for the care of the chronic sick, taking into consideration the type and size of community and the availability of other hospital facilities.

Fair Hearing: A list of participating hospitals is to be published and from time to time revised by the Surgeon General, on the basis of general standards prescribed by him after consultation with the Advisory Council. Any institution not included in the list, or withdrawn from the list, may file a petition to be included, setting forth the necessary information to show that it meets the requirements for a participating hospital. An institution whose petition is denied shall, if it so requests, be given reasonable notice and opportunity for a fair hearing.

Federal Control Prohibited: The Surgeon General is forbidden to exercise any supervision or control over a participating hospital (other than a hospital owned, or leased, and operated by the Federal Government), or to impose any requirement or make any agreement which would prescribe its administration, personnel or operation.

Methods of Payment: Two methods of payment for hospitalization benefits are provided in the bill:

1. A hospitalization benefit is defined as an amount of money, as determined by the Surgeon General after consultation with Advisory Council, of between $3 and $7 for each of the first thirty days in a period of hospitalization, between $1.50 and $4.50 for each day in excess of thirty, and between $1.50 and $3.50 for each day in an institution for the care of the chronic sick. This amount may be paid to the beneficiary or, by arrangement, direct to the hospital.

2. Alternatively, the Surgeon General may enter into contracts with participating hospitals to pay them the reasonable cost of the hospitalization services they furnish eligible persons, within the minimum and maximum rates per day specified for hospitalization benefits. Such payment is to be full reimbursement for the cost of essential hospital services including the use of ward or other least expensive facilities compatible with the proper care of the patient. However, the hospital may charge patients the cost of more expensive facilities furnished for lack of ward facilities or occupied at the request of the patient, and for special services not included in the contract between the hospital and the Surgeon General.

Inclusive Services of Hospitals: The Surgeon General is also authorized to negotiate agreements or cooperative working arrangements to utilize the inclusive services of hospitals and their staffs and/or attending staffs, and to pay under a single contract, for hospitalization services, and for general and special medical and dental services.

Reports on Additional Benefits and on Care and Prevention of Chronic Sickness and Mental Diseases

Benefits Not Currently Furnished: The Surgeon General and the Social Security Board are jointly responsible for studying, and for making reports and legislative recommendations not later than 2 years after the bill is enacted, as to the most effective methods of providing dental, nursing and other needed benefits not currently furnished, the expected cost of such benefits and the desirable division of costs between (a) the Personal Health Services Account or other public funds and (b) payment by beneficiaries.

Care and Prevention of Chronic Sickness and Mental Diseases: The Surgeon General and the Social Security Board are jointly responsible for studying, and for making reports and legislative recommendations not less than 3 years after the bill is enacted, as to needed services and facilities for the care of the chronic sick and of individuals afflicted with mental or nervous diseases, and of needed provisions for the prevention of chronic physical diseases and of mental nervous diseases.

Grants-in-Aid for Medical Education, Research and Prevention of Disease and Disability

Research and Professional Education: To encourage and aid the advancement and dissemination of knowledge and skill in providing personal health service benefits and in preventing illness, disability and premature death, the Surgeon General is to make grants-in-aid to nonprofit institutions and agencies engaging in research or in undergraduate or post-graduate professional education. The grants are to be made with respect to projects (a) for which an application has been received

from a nonprofit agency and (b) which the Surgeon General determines - with the advice of the Advisory Council and after consultation with other federal agencies concerned with research or professional education - holds promise of valuable contributions to the education or training of medical and health personnel or to human knowledge with respect to the prevention or treatment of disease and disability.

Preference for Servicemen: Priority is to be given, during the five years beginning January 1, 1946, to projects to aid servicemen and servicewomen seeking post-graduate education as medical or dental practitioners or training for administration of personal health services, disability benefits, rehabilitation services and related services.

Appropriations: The amounts available for such grants-in-aid are to be $10,000,000 for the calendar year 1946, $15,000,000 for 1947 and for each calendar year thereafter, an amount equal to 2 percent of the amount spent for personal health service benefits in the preceding fiscal year.

Personal Health Services Account

A separate account, known as the Personal Health Services Account, is to be created on the books of the Treasury of the United States. There is authorized to be appropriated to the Account the amounts needed to finance the benefits, payments and reimbursements of the prepaid personal health service benefits system. From such appropriations there is to be credited to the Account:

1. Amounts equal to 3 percent of wages, up to $3,600 a year in covered employments.

2. The cost of dental and home nursing benefits.

3. The amount expended for social security beneficiaries who became insured before the bill goes into effect.

4. Reimbursements made to the Account on behalf of non-insured persons (needy persons, workmen's compensation cases, etc.)

Covered Employment and Wages

"Wages" Defined: The term "wages" for the purposes of this program is defined to mean all remuneration for employment up to $3,600 a year. Remuneration includes the cash value of remuneration paid in any other medium, and sums paid under an order of the National Labor Relations Board of a comparable state agency, but does not include any payments to or on behalf of an employee under employer retirement or insurance plans meeting specified conditions, employee social insurance contributions paid by the employer or the value of services exchanged for other services.

"Covered Employment" Defined: Covered employment means all employment after June 30, 1946, including self-employment, except government employment (but service for the T.V.A. on an hourly basis is covered), railroad employment, service performed by ordained ministers or regular members of religious orders, casual labor, service for a foreign government or on a foreign vessel outside the United States, and a few minor categories of employment.

"State" Defined: For the prepaid personal health benefits program, the term "state" includes Alaska, Hawaii and the District of Columbia.

(By permission of Child Welfare Information Service, Inc.,) (Issue No. 62, Washington, D.C., March 11, 1946)

EXHIBIT "D"

DIGEST OF CALIFORNIA HEALTH SERVICE ACT (AB 800) 1945

This Act proposes to establish a system of prepaid health service for the people of the State of California and seeks to:

(1) Provide a fund from which medical and hospital costs may be met.

(2) Make the highly improved facilities resulting from progressive modern medical science available to a greater segment of the State's population.

(3) Insure an adequate and sure compensation to those furnishing medical and hospital facilities.

(4) Encourage the affected professions and organizations to increase their facilities and offer higher standards of performance.

According to its provisions, personal health service benefits will be available to every employee and each of his dependents. "Employee" is defined as an individual performing services in employment for an employer subject to the State Unemployment Insurance Act. Any employee, earning more than $5,000.00 per annum, and his dependents are not eligible to receive any health benefits. Also, the Act does not include agricultural labor, domestic service, employees of the United States or Foreign Government, members of religious orders and/or uncompensated officers of eleemosynary corporations or associations and employed students. However, the Commission may, by contractual engagements, make the health services available to any resident of the State who is neither an employee nor the dependent of an employee within the meaning of this Act. Individuals are not entitled to receive benefits if they could receive similar benefits or care under any workmen's compensation law or employer's liability law.

Health service benefits available are: (1) Basic Services and (2) Additional benefits. Basic services includes general practitioner services rendered by a licensed physician or surgeon at the office, hospital, clinic, home or elsewhere required by the standards of good medical practice for preventive, diagnostic, therapeutic care; consultation and specialist services; laboratory and X-ray services; necessary hospitalization, excluding ambulance services, for a period not to exceed 21 days in any calendar year for each separate illness; drugs, and medicinal supplies prescribed by the attending physician; general nursing service; dental services only for the treatment of the diseases and injuries of the jaws and dependent tissues including tooth removal but excluding any replacements. Hospitalization includes only ward accommodations but the patient, upon his request and payment of the difference, may secure higher priced accommodations. Services are furnished for tuberculosis and mental infirmities or disorders only up to time of diagnosis of such conditions. Availability of additional service benefits are dependent upon the financial status of the Health Service Fund and, by authority of the Commission, include: Increase of the hospitalization period, additional drugs, additional medical or dental services, ocular refraction or providing ophthalmic materials. In all cases, the patient is given free choice of physician and/or hospital registered under this Act.

The cost of this medical and hospital plan would be financed primarily by a levy of a employer-employee tax of one and one-half percent (1½%) and, in the event monies thus collected are insufficient, additional funds are to be provided by the state. According to the proviso, every employer is to pay into the Health Service Fund one and one-half percent (1½%) of all wages paid by him for employment falling within this act. Such taxes are payable upon five thousand dollars ($5,000.00) or less of wages paid in any calendar year to any employee by such employer. Each employee performing services for an employer subject to this act, is to pay into the fund an amount equal to one and one-half percent (1½%) of his wages up to five thousand dollars ($5,000.00) in any calendar year paid by the employer. Self-employed persons accepted by the Authority for participation are subject to the same taxes. Any individual who adheres to the faith or teachings of any well-recognized religious organization and in accordance with its principle, depends for healing upon prayer and the practice of religion, who is employed by an employer, is exempted from this tax upon filing with the Authority an affidavit to that effect. His employer is also exempt from paying tax with respect to wages paid that employee.

The responsibility of administering this Act is placed in the hands of the California Health Service Authority consisting of 11 members and a manager. The Authority will function as a part of the Department of Public Health. The Director of Public Health is the ex-officio member while the Governor appoints the other 10 members as well as designate the chairman of the Authority. The term of office is limited to 4 years, same to be staggered as provided in the act, and until successors are appointed and qualified. Relative to appointment, the act specifically provides that the full membership of the Commission at all times consist of:

(a) Three representatives of employer including one employer of agricultural labor.

(b) Three representatives of employees, including two of organized labor and one public employee.

(c) Three persons holding licenses as physician and surgeon, one of whom is experienced in hospital management.

(d) One licensed dentist.

(e) Director of Public Health.

The Authority is empowered to advise the manager in the performance of his duties and to formulate general policies affecting the purposes, responsibilities and jurisdiction of the Act, including the power to adopt, promulgate, repeal and amend rules necessary or advisable to carry out its provisions. It also has the power to:

(1) Prescribe standards of health service to be furnished under this act.

(2) Prescribe rates, fees or charges to be claimed and paid for all health services furnished under this act.

(3) Adopt a procedure for the establishment and payment of claims.

(4) Review and settle disputed cases.

(5) Provide a procedure for the registration of physicians, surgeons, dentists, optometrists and hospitals for the purpose of rendition of health service.

(6) Investigate any registered hospital to determine its compliance with the Act.

The Manager is the executive officer who, upon the recommendation of the Authority, is appointed by and serves at the pleasure of the Governor. He acts as secretary to the Authority and is charged with the proper administration of its rules and regulations.

EXHIBIT "E"

THE HEALTH INSURANCE MOVEMENT IN CANADA *

A. Background.

1. Although Canada is slightly larger than the continental United States, the population is approximately twelve million - somewhat less than that of New York State. The Pre-Cambrian Shield, 1000 miles in width which divides the east from the west is largely uninhabited.

2. Economically, Canada is influenced by and closely connected with the United States. Like the separate States of the Union, the provinces of the Dominion have health needs which vary.

3. The Western provinces began official health planning in 1919 when a legislative commission in British Columbia recommended compulsory health insurance. Legislation enacting such insurance was passed in 1936 but because of opposition from the medical profession was not made effective.

   Saskatchewan also began official planning in 1920 and to date has progressed, with Manitoba, toward realization of operating plans. They will be discussed in more detail later. The province of Alberta also passed a Health Insurance Act in 1935 but because of political opposition the Act has never functioned.

4. On the Federal level a Committee of the Dominion House of Commons studied the issue in 1928, and 1929. However, the activities of the Federal government have been retarded in developing a scheme because of the fact that the province is, by constitution, the sovereign power (B.N.A. Act, 1867).

5. In 1935, a national system of contributory unemployment insurance was enacted but an amendment to the constitution had to be obtained before it could be put into operation. The original plan had been to authorize the administrative commission to study, and report upon medical care and hospitalization but nothing was specified in the amendment as to the powers of the Dominion in the health field.

6. In 1940, the Dominion Council of Health was directed by the Prime Minister to discuss the whole subject of public health and medical care. The council adopted resolutions recommending grants to the provinces for public health purposes and also recommending health insurance.

7. This led to the formation in 1942, of an Advisory Committee on Health Insurance. The Committee, headed by Dr. J. J. Heagerty, Director of Public Health Services, made extensive surveys and studies of needs and personnel. It called quite freely for help and advice from all professions concerned.

8. In 1943, the Committee submitted its volume of studies and supporting data together with draft bills for Dominion and Provincial consideration to the Minister.

B. Provisions of the National Health Bill.

1. As stated above the system is a Dominion - Province one. The basic features are as follows:

   a. Assures the highest quality of medical care.

   b. Will be adaptable enough to meet local conditions in various provinces.

*Prepared by Bureau of Public Health Economics, School of Public Health, University of Michigan, 1946.

c. Will use provincial health services already available.

d. Is capable of being introduced in several stages if the province desires.

e. Is capable of being introduced in separate areas if such approach is desirable but a time limit must be set for complete coverage.

f. The National plan must outline the services which are to be provided but the provinces shall determine the particular methods by which the services will be available in accordance with their view of what suits their province best.

g. As far as possible, the existing personal relationship between the doctor and the patient must be maintained.

2. The National Bill. "The Health Act."

a. The essential feature is to authorize agreements between the Dominion government and any province relating to grants-in-aid made available to the province for the support of public health services and medical care. In order to be entitled to the grants the province is required to make provision in its own Health Act for both preventive and curative services.

b. Grants-In-Aid to the Provinces.

(1) Health Insurance Grants. It is conceded that the province can choose to go into health insurance in two stages. The following table illustrates the basis of Dominion contribution for Health Insurance.

Service Provided	Estimated Average Cost	o/o Total Cost o/o	Basic Dominion Grant	Maximum Additional Grant
First Stage (Total)	$10.20	$48.0	$2.04	$4.08
Gen. Practitioner	6.00	28.0	1.20	2.40
Hospital Care	3.60	17.0	0.72	1.44
Visiting Nursing Service	0.60	3.0	0.12	0.24
Second Stage (Total)	11.40	52.0	2.28	4.56
Other Method (Specialist)	3.50	16.0	0.70	1.40
Private Duty Nursing	1.15	5.0	0.23	0.46
Dental Care	3.60	16.0	0.72	1.44
Drugs, etc.	2.55	12.0	0.51	1.02
Laboratory Services	0.60	3.0	0.12	0.24

The province must agree to establish the services noted under "First State" within two years after entering the plan.

(2) Public Health grants - for tuberculosis; mental diseases; venereal disease; "general public health." Special grants are to be made for professional training of personnel; public health investigations; physical fitness.

c. Administration - Placed under the Minister of Pensions and National Health. The law provides for a National Council on Health Insurance. Members of the Council are to be the Ministers and Deputy Ministers of health in each province; also administrative officers of health insurance in provinces; representatives of the health professions and lay representatives. Its functions are not specified. No doubt it will act in an advisory capacity to the Minister.

3. The Provincial Bill.

a. Coverage - Every inhabitant regardless of economic or social status. The cost of care for children under sixteen years of age will be borne equally by the entire population.

b. Cost - $26 per capita per year - or an average of 50 cents per week. Nevertheless, 3 percent tax in income is the limit and if the employees wages are $700 his tax would only be $21, the other $5 to be paid by his employer. If he is self-employed, or not employed at all, public funds (provincial with Dominion aid) will make up the deficit. Payment for the indigent will be made entirely from public funds. The stamp system will serve as means of tax collection.

c. Physicians Services

(1) Any licensed physician may participate. Each must indicate what service he is qualified to give and will be paid only for such service.

(2) Free choice - Specialists and consultants will, "ordinarily" be recommended by the general practitioner. However, the patient is free to choose from the listed specialists.

(3) Payment

(a) Capitation
(b) Fee-for-service
(c) Salary
(d) Combination

(4) Form of practice may be either Group or Individual.

d. Hospital Care.

(1) Types of hospital in which care may be rendered are the non-profit voluntary or any of the governmental hospitals. Proprietary hospitals are not recognized.

(2) Payments to hospitals are to be on a basic per diem rate with agreed provisions of extra services or through an inclusive per diem rate covering all services.

(3) General ward care only - but patients have the right to pay with their own means for private or semi-private rooms when such are available. When such accommodations are essential for the patient's welfare and are ordered by the attending physician the insurance fund will "foot" the bill.

(4) Patients have freedom of choice of hospitals.

(5) Hospitals retain the right of appointing their medical staffs.

(6) Teaching hospitals are protected by special provisions.

e. Nursing Services - Limited home nursing will be provided when ordered by the physician.

f. Dental Services - Limited services at first, mainly children's preventive dentistry. Extension of services to other age groups as personnel and facilities increase.

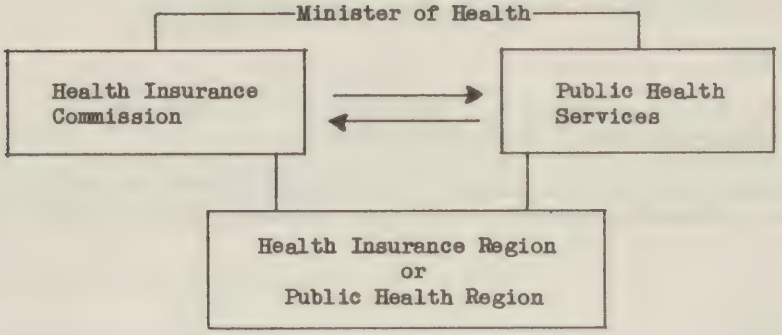
g. Drugs, medicines, materials and applicances - are to be provided on the order of a physician subject to arrangements with pharmacists.

h. Administration - A Health Insurance Commission is to be set up, the chairman is to be a physician appointed by the Lieutenant-Governor in Council. The members will include the Province Health Officer - ex-officio, and other representative members of the various health professions, insured persons, industrial workers, employers, agriculturists, etc. The Commission is empowered to:

(1) Make its own by-laws and regulations.

(2) Set up necessary Committees including those for handling of complaints.

(3) Localize administration by dividing its provinces into districts which are to be known as "Public Health Regions" for public health purposes and "Health Insurance Regions". There shall be established under a unified administration all public health services and health insurance services. Thus, a close correlation will exist between the two, and in the outlying districts wherever it is possible, the public health officer will also be the health insurance administrative officer.



C. Current Status of the Bill.

1. The comprehensive Bill has not yet been passed by the Dominion, though Manitoba and Saskatchewan have proceeded with their own plans. It seems to have been delayed by the inability of the Dominion and various Provinces to arrive at solutions to the questions of taxing rights and tax allocations. The Provinces are fearful of too much centralization.

2. However, a step forward was realized in July, 1945, when the Family Allowances Act went into operation under the direction of the Minister of Health. This law should act in some measure toward insurance of the health of Canada's children.

D. Professional and Lay Attitudes.

1. Canadian Medical Association. This organization has always recognized Canada's need and has been most cooperative with the government. The Canadian government has freely called on the Association for help and advice and the lack of bickering between the profession and the Dominion is noteworthy. This does not mean that the organization has been in complete accord with the Government in all points. In 1943, the Association went on record in favor of a comprehensive plan of health insurance and listed fourteen fundamental points which they considered essential:

a. The plan should provide a high standard of health service for the people.

b. It should cover all people of low-income including dependents and those generally known as "indigents"; the latter should receive medical care under exactly the same conditions as other insured persons.

c. The plan should be obligatory for persons whose annual income is insufficient to meet the costs of adequate medical care. This income level should be left for determination in the individual province.

d. The administration in the provinces should be under a non-political commission working in close cooperation with the department of health.

e. Those receiving and those providing the services should be equitably represented on the commission or its advisory committee.

f. The insurance fund should receive contributions from the insured, the employer (if any) and the Government.

g. The plan should be sound actuarially.

h. Preventive medicine and public health measures should be a feature of the plan.

i. No economic barrier should be imposed between the doctor and patient.

j. The professional side of the medical service should be the responsibility of the medical profession through central and local medical services committees.

k. Free choice of medical practitioner should be permitted.

l. The remuneration of those providing the services should be consistent with the high quality of the service expected of them. The basis upon which doctors will be paid should be worked out in cooperation with the profession.

m. The vitally important continuance of the medical schools should be safe-guarded.

n. Research should be supported.

2. Canadian Dental Association. This organization has also cooperated very freely with the government. In 1943 it presented to the Advisory Council a proposed compulsory dental program for its consideration. The basic principles for such a program outlined by the association are:

a. That the plan be national in character.

b. That each Provincial Government be free to choose the adoption of the plan, the method of application best suited to meet the dental needs of its people and the administration of the monies.

c. That the administration of the plan be through the cooperation of the Provincial Government and the Dental Board as provided under the Provincial statute regulating the practice of dentistry, of the various provinces as constituted at the present time.

d. That the practice of dentistry be carried on in the private office of the dentist except under circumstances not favorable to private practice.

e. That the regulating of the plan and the proper allotment of funds to be expended for dental health service be proportioned and adjusted by agreement between the Provincial government and the Provincial Dental Board as defined in Clause (c). A standing committee to be set up for that purpose. This committee to consist of five persons, three appointed by the Dental Board and two by the Provincial Government.

f. That the following features be observed:

(1) Every qualified dentist in good standing be eligible to practice under the plan.

(2) The patient to have the freedom of choice of dentist and the dentist to retain the right to refuse attendance upon the patient subject to geographic, ethical or professional considerations.

(3) The basis of dental service be, to make available the services of the dentist in general practice - the referring of patients for any special services to be made through said dentist.

g. That preventive dentistry rather than restorative dentistry shall hold the dominant position.

h. That there shall be no interference with the development and progression of the recognized dental professional standards.

i. That adequate provision shall be included for the encouragement and support of research in dentistry.

j. That any plan adopted shall provide for the indigent on an equal basis with those who are in a position to make contributions.

k. That the determination of the need for dental services shall be the prerogative of the dental profession.

According to the Canadian Dental Association, the following benefits should be available to each insured person:

a. A dental examination shall be given once every six months.

b. Prophylactic treatment shall be given once every six months, when necessary.

c. Plastic fillings materials shall be used in restorative work.

d. Provision shall be made for the use of special materials and appliances for the treatment of accident cases.

e. Extractions and necessary dental surgery are to be performed when necessary.

f. Anesthetics shall be used where necessary.

g. Arrangements shall be made available whereby the patients may be referred for special services.

h. Radiograms are to be used where considered necessary.

i. Provisions shall be made for the use of such other materials as may be required in carrying out the usual procedures in the practice of dentistry for children.

3. Canadian Hospital Association favors a health insurance plan but points out that more hospital beds are essential to carry out such a program.

4. Canadian Public Health Association. This organization expressed a willingness to cooperate in the development of an adequate plan for Canada, stressing the fact that as much preventive medicine as possible should be included in the work of the general practitioner.

5. Canadian Nurses Association - also assured the Advisory Council that they very earnestly desired to share in the development of a plan which "would safeguard and promote the health of the people of Canada."

6. Labor. March, 1945 the Committee on Economics of the Canadian Medical Association held a series of discussions with leaders of various organizations, among them the heads of several national labor organizations. Labor is in favor of compulsory insurance but the representatives expressed themselves particularily on the following points:

a. Want greater preventive service;

b. More control of patent medicines;

c. Believe hospitals should not have to depend so much on charity;

d. Do not wish incomes of physicians reduced;

e. Favor the protection of medical teaching, provided all patients under the plan are subject to clinical teaching;

f. Feel the importance of high quality medical education.

7. The Layman's View.

a. The Canadian Institute of Public Opinion released the results of a Gallup Poll in 1942, which expresses this attitude admirably. The question asked was "If the Government should start a National Health Plan, would you be willing to pay a small part of your (or your family's) income every month so that you and your family would receive medical and hospital care whenever you needed it?" The question was put to all types, from coast to coast and the answer was as follows:

Would be willing	75%
Would not be willing	18%
Undecided	7%

b. The layman also insists on adequate representation on any of the Advisory Boards. His plea is that health insurance administration not be the monopoly of any group, professional or otherwise.

E. Action in the provinces.

1. Saskatchewan

a. The Municipal Doctor System. This system has been utilized by the western provinces since 1919. The local unit of government here is an area consisting of 200 to 300 square miles with a population of from 1,200 to 3,000 persons. By this system a doctor is engaged on a salary basis for the benefit of the population of an area.

This is done by either:

(1) Making a grant not exceeding $1,500 annually to induce a physician to establish a practice within the community.

(2) Engaging the services of a physician for the municipality at a sum not exceeding $6,000 per annum. If the area exceeds 9 townships they may pay $600 for each additional township. Funds are collected by taxation.

(3) By 1944, 103 of 343 municipalities functioned under this plan.

b. Health Services Planning Commission.

(1) Established in 1944 for the purpose of working out the details and successive steps through which health services could be instituted. The plan is to divide the province into health units under a full time health officer who will be responsible for the coordination of all health services in the region in addition to his regular duties. Hospital and laboratory clinics are to be improved and traveling clinics are to be established. The municipal Doctor plan is to be the basis of medical care in the rural areas.

c. Legislation in 1945

(1) Establishment of free health and hospital services for old age and blind pensioners and dependents.

(2) Establishment of Mothers' Allowance, and also allowances for children who are wards of the state.

d. Legislation in 1946

(1) Introduction by the Government of a measure which would provide care without cost to all residents of the province. Hospitalization Act of 1946.

(2) Health Services Act introduced. This Act paves the way for a broader form of health insurance.

(3) Medical Cooperative in Saskatoon asks that the legislature amend the Professional Services Act so that it (the Legislature) will have specified powers over the College of Physicians and Surgeons. Its feeling was that the state and not the College should license the physicians. It also asked that all by-laws passed by the medical profession be subject to the approval of the public health department.

(4) The United Farmers of Canada, Section of Saskatchewan, requested the Legislature to amend the Professional Services Act to the effect that there will be public representation in the governing body of the new medical college at the University in Saskatoon.

2. Manitoba.

a. The Municipal Doctor System. This was adopted in 1920 and has been very satisfactory in

those areas where it has been used.

b. By 1944, only 21 municipalities had passed the necessary by-laws to bring the plan into operation.

c. Legislation in 1945. Passage of the Health Services Act. This Act aimed to:

(1) Provide full time health units covering the whole province. Establishment of a unit depended on its voluntary acceptance by the municipality. Administration and control of the unit is to be in the hands of a board, the majority of whose members are local appointees.

(2) Cost estimated to be one dollar per capita per annum.

(3) Diagnostic facilities will be compulsory in all hospitals.

(4) Diagnostic facilities will be provided free except for a small fee of fifty cents per person.

(5) Introduction of general practitioner services at an estimated cost of $3.00 per person per year. Manner of payment to be decided by the practitioners and their respective municipalities.

(6) Improve hospital facilities by dividing the province into hospital areas.

(7) The Act is administered by the Department of Health with the assistance of an Advisory Commission of eleven members. Commission membership includes representation of:

Department of Health and Welfare
Canadian Medical Association
Board of Governors of the University of Manitoba
Faculty of Medicine of the University of Manitoba

d. Status of Health Service Act in 1946.

(1) Six full time health units now operating.

(2) Total population covered is approximately 62,000.

3. Alberta.

a. Legislation in 1946. Passage of Health Services Act. Provides health services for the people of Alberta. The Act includes the following benefits for any adult who has resided in the province for 12 months out of the 24 immediately preceding his registration in his Health Insurance District. The Act also provides the following benefits for each dependent of an adult or for the indigents of the municipality:

(1) Medical, surgical and obstetrical benefits.

(2) Dentistry

(3) Pharmacy

(4) Hospital

(5) Nursing

b. The voters of each District decide whether or not the plan goes into operation. If 60 percent vote in favor of it, the plan will be instituted. If, after a year's operation of the plan, 25 percent of the adults sign a petition and present it to the Director of Health Insurance he may abandon the plan. Cost per person per annum is not to exceed $10.00. The province will meet at least 60 percent of the total cost.

c. Administration of the act will be in the hands of the Minister of Health through a Director of Health Insurance and assisted by an advisory committee.

EXHIBIT "F"

DIGEST
OF
CALIFORNIA UNEMPLOYMENT COMPENSATION DISABILITY ACT

(Supplement to the California Unemployment Insurance Act)

HISTORY: Act became effective May 21, 1946. Benefits became payable on December 1, 1946.

PURPOSE: To provide payment of cash benefits to any individuals suffering wage loss as a result of unemployment caused by any illness or injury except those arising out of or in connection with pregnancy up to the termination of such pregnancy and for a period of four weeks thereafter.

SCOPE OF COVERAGE: All individuals covered by the provisions of the California Unemployment Insurance Act. However, employees may vote for and take coverage provided by a private plan which meets requirements set forth by statute and by the state's governing authority of this Act.

BENEFITS AVAILABLE: Benefits, in form of cash payments, are:

1. Established according to the highest amount of wages earned for any one quarter of a calendar year immediately preceding the claim. Present effective annual wage and benefit schedule shows:

a. Minimum Total Wage Earned ------ $300.00. Minimum Total Benefit Credits ----- $160.00.

b. Maximum Total Wage Earned -- $2,000 to $3,000. Maximum Total Benefit Credits -- $468.00.

2. Payable weekly. Rates thereof calculated on the highest amount of wages earned by an individual during any one quarter for the previous calendar year. Present approved schedule of rates show:

a. Least one may receive per week to be $10.00.

b. Most one may receive per week to be $20.00.

3. Limits of benefit periods approximate:

a. Minimum of 9 weeks.

b. Maximum of 23 weeks.

4. Are subject to reduction upon declaration of an emergency by the Governor if required to protect the solvency of the disability fund.

5. Limited, in that an individual may not receive full time benefits from more than one source, i.e. a person may not receive disability benefits in the same week in which he receives unemployment compensation or workmen's compensation benefits.

PRE-REQUISITES: The Act provides that:

1. There shall be a waiting period of one calendar week for each period of disability.

2. Sick person must file a written claim and shall present a certificate from a physician as to his disability.

3. An individual must have submitted to physical examinations as required by the Commission.

ADMINISTRATION: Act administered by the Employment Stabilization Commission of the Department of Employment which:

1. Has the authority to establish rules and regulations to effect sound and economical administration.

2. Has the authority to approve voluntary plans providing such plans afford greater benefits than available under this Act and that such plans conform to specified requirements.

3. Has the authority to hear, determine and settle appeals of denial of claims for disability benefits under a voluntary plan.

METHOD OF FINANCE: Cost financed by the payroll tax of one percent (1%) on employee's earnings not exceeding $3000.00 per annum initially collected as part of the unemployment compensation tax levy.

CONTROL OF FUND: Tax collected is deposited into a Disability Fund administered by the Commission.

EXHIBIT "G"

DIGEST
OF
RHODE ISLAND CASH SICKNESS COMPENSATION ACT
(As amended by the State General Assembly January, 1946)

HISTORY: Act establishing system became effective May 10, 1942. Levy of Taxes began June 1, 1942. Benefits became payable on and after April 1, 1943.

PURPOSE: To provide cash sickness insurance for any employee suffering wage loss as a result of being unable to perform his regular or customary work because of his physical or mental condition.

SCOPE OF COVERAGE: Every employed person in all employment except:

1. Agricultural labor
2. Domestic service
3. Maritime service
4. U.S. Government
5. State and all political subdivisions therein
6. Non-profit and/or eleemosynary corporations
7. Students
8. All retired employees who have not worked for six months or who have not applied for employment at the U.S. Employment Service

BENEFITS AVAILABLE: Benefits, in the form of cash payments, are:

1. Established according to the total earnings of an employee for the previous calendar year. Present effective wage and benefit schedule shows:

a. Minimum Total Wage Earned ------ $100.00. Minimum Total Benefit Credits ------ $34.00.

b. Maximum Total Wage Earned - $1,800. and over. Maximum Total Benefit Credits - $364.50.

2. Payable weekly. Rates thereof calculated on the highest amount of wages earned by the employee during any one quarter in the preceding calendar year. Present approved schedule of rates shows:

a. Least one can receive per week to be $6.75

b. Most one can receive per week to be $18.00

Further projected, limits of benefit periods approximate:

(a) Minimum of 5 weeks
(b) Maximum of 20 weeks

3. Limited, in that it stops upon exhaustion of total benefit credits.

4. Limited, in that benefits from the workmen's compensation and cash sickness compensation may not exceed 90% of the employee's average weekly wage at his last regular employment.

PRE-REQUISITES: The Act provides that:

1. There shall be a waiting period of one calendar week to any benefit year.

2. Sick employee shall file written benefit claim in accordance with rules prescribed by the Board.

3. Such claims shall be certified by the claimant's physician or physicians employed by the Board.

ADMINISTRATION: Act administered by the Unemployment Compensation Board (Dept. of Labor) which:

1. Is comprised of three (3) qualified electors (no two from same party) appointed by the Governor and confirmed by the Senate:

a. One (1) representative of labor

b. One (1) representative of industry

c. One (1) representative of public

2. Shall serve under general supervision of Director of Labor.

3. Has authority to establish rules and regulations to effect sound and economical administration.

4. Has authority to modify or change existing rules and regulations to protect and assure solvency of funds.

5. Is compensated (chairman: $6,000.00 - members: $5,000.00)

6. Shall appoint referees to handle any appeals, disputes and/or differences.

METHOD OF FINANCE: Cost financed by payroll tax of one and one-half percent (1½%) on employee's earnings not exceeding $3,000,00 per annum. Collected as part of the unemployment compensation tax levy.

CONTROL OF FUNDS: Tax collected deposited into Cash Sickness Compensation Fund which is:

1. Administered by the Board.

2. Held in custody by General Treasurer.

EXHIBIT "H"

STATE AND TERRITORIAL PROVISIONS RELATIVE TO THE LICENSING OF PHYSICIANS

(Compiled from American Medical Directory, 1942)

Florida, Idaho, Massachusetts, Rhode Island, Hawaii, and the Philippines are the only states and territories, about which information is available, which have no reciprocity with other states or territories, relative to the licensing of physicians.

Of the above mentioned states and territories, holders of certificates from the National Board of Medical Examiners will be registered without further written examinations in Idaho, Massachusetts, Rhode Island and Hawaii. Candidates for licensure in Rhode Island and Hawaii are given an oral examination by the state board.

Hawaii, alone, requires stipulated residency of all applicants, prior to licensure.

NOTE

The following legend for the chart on Licensing of Physicians, refers to information which is found under:

1. National Board of Medical Examiners, pages 99-100, and/or
2. Digest of Law and Board Rulings for the respective state or territory, pages 265-2020, inclusive.

LEGEND

* Graduates of foreign medical schools, except Canada, are not acceptable.

*a Graduates of medical schools outside the United States are not acceptable.

*b Full citizenship required of all applicants from all European and Asiatic countries.

*c Graduates of foreign medical schools not eligible.

** Medical officers of the U.S. Army, Navy and Public Health Service will be licensed (with or without oral examination) on filing satisfactory credentials.

**Rl Reserve medical officers of the U.S. Army, Navy and Public Health Service not eligible.

**R Retired medical officers of the U.S. Army, Navy and Public Health Service will be licensed (with or without oral examination) on filing satisfactory credentials.

f Diplomates licensed after passing an oral examination.

fa Diplomates licensed at the discretion of the Board.

fb Will accept diplomates who have passed the examination within five years prior to making application.

fc Diplomates will be licensed after successfully passing the basic science examination.

fd Requires supplemental written examination of all diplomates.

1. If that state accepts licentiates from this state.
2. If the applicant has been in active practice two years in the state from which he applies.

3. License issued in another state must be followed by at least one year's practice or internship subsequent to the date of issuance.

3a License issued in another state must be followed by one year's practice subsequent to the date of issuance.

3b Requires one year of residence in some states after a candidate becomes a diplomate.

4. All reciprocity candidates must pass a clinical test before being licensed.

5. All candidates must present themselves for a personal interview.

LICENSING OF PHYSICIANS

State	Licensed Reciprocity with States	Without Exam. Nat. Board License	Residence Prior to License	Citizenship	
Name	Number	Yes	Time	Yes	No
1. Alabama	41 (1)	x (**R)		x	
2. Arizona	Any equal	x (**R) (fc)		(*)	
3. Arkansas	38	x		x (*)	
4. Calif.	Special requirements (3b)	x (**Rl)			x
5. Colorado	Any equal (3)	x (**) (fc)		x	
6. Conn.	Any equal	x (f)		x	
7. Delaware	Any (1) (2)	x		x	
8. D. C.	Any equal	x			x
9. Florida	None			x	
10. Georgia	37	x		x	
11. Idaho		x (fb)		x	
12. Illinois	32 (4)	x (f) (**)		x	
13. Indiana	35	x			x
14. Iowa	36	x		(*b)	
15. Kansas	38	x		x	
16. Kentucky	35	x		x	
17. Louisiana	42			(*)	
18. Maine	35	x (f)		x	
19. Maryland	Any conditional (5)	x		x	

LICENSING OF PHYSICIANS

Exhibit H (cont'd)

State	Licensed Reciprocity With States	Without Exam. Nation. Board License	Residence Prior to License	Citizenship	
Name	Number	Yes	Time	Yes	No
20. Mass.	None	x		x	
21. Michigan	Any equal	x(f) (fc) (fd)		x	
22. Minn.	35 (4)	x		x	
23. Miss.	Any equal	x		x	
24. Missouri	Any equal(1)	x		x	
25. Montana	32	x(f)		x	
26. Nebraska	Any condi-(3) tional	x		x	
27. Nevada	30	x(f)		(*)	
28. N. H.	Any equal	x		x	
29. N. J.	Any condi tional	x		x	
30. N. M.	Any equal	x		(*)	
31. New York	Any equal	x		x	
32. N. C.	Any condi-(5) tional	x(**R)		x	
33. N. D.	30(3a)	x(fa)		(*b)	
34. Ohio	43	x		x	
35. Oklahoma	Any equal - Conditional	x (fc)		(*)	
36. Oregon	Any equal - Conditional	x (fc)			
37. Pa.	Any equal	x (**)		x	
38. R. I.	None	x (f)		x	
39. S. C.	19	x		(*c)	
40. S. D.	33	x (**)		x	
41. Tenn.	37	x		(*)	
42. Texas	Any equal			x	
43. Utah	Any condi-tional	x (**R)		x(*c)	
44. Vermont	Any equal -(5) Conditional	x		x	

LICENSING OF PHYSICIANS

Exhibit H (cont'd)

State	Licensed Reciprocity with States	Without Exam. Nat. Board License	Residence Prior to License	Citizenship	
Name	Number	Yes	Time	Yes	No
44. Vermont	Any equal - Conditional (5)	x		x	
45. Virginia	34	x (**)		x	
46. Wash.	26	x (fc)		x	
47. W. Va.	35	x		x (*)	
48. Wisconsin	Any equal - Conditional	(**R)		(*)	
49. Wyoming	Any conditional	x (f)		(*a)	
1. Alaska	21, equal requirements	x		x	
2. Canal Zone		x			
3. Hawaii	None	x (f)	1 year	x	
4. Philippines	None				
5. Puerto Rico	1	x (**)			
6. Guam					
7. Johnston Island					
8. Midway Islands			No data		
9. Virgin Islands					
10. Wake Island					

EXHIBIT "I"

DIGEST OF THE ANDREWS BILL

RBJ
514:26

April 16, 1946

Territorial Hospital Service
Study Commission
Iolani Palace
Honolulu, Hawaii

Gentlemen:

You have requested a brief summary of House Bill No. 659 of the 1945 session of the legislature. This bill is long and complicated, with 48 sections. Any brief summary of it must be general, indicating only a few important characteristics.

The bill proposes to set up in the Territory a system of health insurance and prepaid health service under a health insurance commission (the president of the board of health of the Territory, the manager of the system, three employer representatives, two representatives of organized labor, one public employee, and three licensed physicians and surgeons) appointed by the Governor.

The Commission would have executive, administrative, contracting, policy-making, and regulation-making powers for the system. The counties would be authorized to appoint county health insurance committees to advise the commission. The manager would be the executive officer of the commission and the administrator of the system. The commission and the manager would be authorized to sue and be sued, to enter into contracts, and to conduct the business and affairs of the system and to act for it.

Certain employees of an employer subject to the territorial unemployment compensation law and all territorial or county employees, and dependents of such employees, would be eligible under certain circumstances to receive "basic" health services (including hospitalization) and perhaps "additional" health services under the system. The "basic" health services, including services for tuberculosis and mental infirmities or disorders only to the time of their diagnosis, would include numerous other services, subject, however, to the commission's power by two-thirds vote to restrict, limit, or modify them. "Additional" health services, including additional hospitalization, might be provided by the commission if the financial resources of the health insurance fund warranted them. No health services would be supplied for any injury which was compensable under any workmen's compensation law or employers liability law.

The services and care would be paid for from the health insurance fund which would be provided by a monthly payroll tax on each employer (1% of the first $400 of wages but not less than $1 for each employee) and by a monthly tax on each employee (in the same amount, withheld and paid by the employer). The system would have the right to reimbursement for services and care for disability, illness, or injury, from damages or compensation to the employee from other sources for the disability, illness, or injury.

Under contractual arrangement the system might render services and care to persons other than the employees who would have the benefit of the system without such arrangement.

So far as practicable and subject to the rules and regulations of the commission, recipients of "basic" and "additional" health services would have the right to request the particular services of general practitioners, surgeons, and other persons registered with the commission to render services under the act. Recipients of health services under the act would not be restricted against providing for themselves at their own expense additional medical, hospital, nurse and other care.

Very truly yours,

(sgd) Ronald B. Jamieson

Ronald B. Jamieson
Deputy Attorney General

EXHIBIT "J"

(Excerpts From)

REPORT OF AUDIT

of the

CIRCUIT COURT, FIRST JUDICIAL CIRCUIT
OFFICE OF THE CHIEF CLERK
CITY AND COUNTY OF HONOLULU

covering the period beginning
July 20, 1943 to and including June 30, 1945

Administration of Small Estates

During the period of audit, 411 regular Small Estate cases were filed and 120 estate cases with assets of less than $200.00, or a total of 531 cases filed.

(pages 23-26)

Weak Policy

Examination revealed weaknesses in the present administrative policy pertaining to Small Estates; mostly weak, in brief, from the following angles:

1. Inadequate inventory records and other supporting data.

2. Inadequate distribution, and escheat of personal effects.

3. Unreasonableness of funeral expenses.

All assets (including articles of no apparent value) should be inventoried, itemized accurately with complete detail, which -- it need hardly be repeated -- forms the basis of the accounting. Description of items of value should be very specific.

Any articles of a personal nature or articles valued as keepsakes should ordinarily be properly distributed among the legatees or next of kin but may be sold if such a distribution is not feasible. If rightful claimants cannot be located after reasonable search and inquiry, any undistributed personal effects should escheat to the Treasury of the City and County as contemplated by law. This agency has the necessary machinery to handle and dispose of such personalty.

It was noted that funeral expenses were generally out of proportion to the character and value of the particular Small Estate, and certainly they are a major item in the total outlay. A definite need of policy exists for fixing some practical standard by proper authority in respect to the reasonableness of necessary funeral expenses.

So far as can be foreseen, legislation should be sought to make the necessary funeral expenses of a decedent (Small Estate) a preferred claim only to a certain reasonably fixed amount. Undertakers could then be adequately warned that claims exceeding the limitation would probably have to be paid other than from the Small Estates.

Here are some samples of uncleared cases which have been pending disposition because of funeral charges (Schedules 3a, b, c).

S. E. No. 3289

Estates of FRANCIS N. KAHALEPUNA, Deceased

Order of Administration — March 27, 1944

Assets:

Cash — $1,161.70

Remarks:

Funeral Claim of $550.00 filed

Deceased left widow and seven (7) minors (Public Welfare Case). Court Order to pay $300.00 funeral expenses. Administrator paid $300.00 on May 3, 1944. Administrator paid an additional $350.00 on April 23, 1945 without any further Court Order.

It was noted Administrator secured refund of $250.00 from undertaker on July 26, 1945.

S. E. No. 3390

Estate of NESTARIO MONTE, Deceased

Order of Administration — August 18, 1944
Order of Distribution — July 3, 1945

Assets:

Cash — $241.05

Remarks:

Brother and sister in the Philippine Islands.

Whatever available information was on file for inspection, was found to be incomplete.

In this conspicuous case, a confusion of facts, pertaining to claims for funeral expenses, was evident from inquiries and other information available.

S. E. No. 3509

Estate of WILLIAM B. WILLING, Deceased

Order of Administration — March 28, 1945

Assets:

Cash — $380.90

Remarks:

Funeral claim of $479.00 filed.

Widow and two minors. Funeral claim paid April 20, 1945 with the $380.90

Order of distribution not signed by judge, pending consideration of apparently excessive funeral expenses.

S. E. No. 3567

Estate of RAYMOND N. K. LOOK, Deceased

Order of Administration — June 12, 1945

Assets:

Cash — $823.78

Remarks:

Funeral claim of $844.00 filed.

Dispute over excessive funeral claim. Court orders $300.00 to be paid. Undertaking establishment refused settlement.

Probable litigation.

. . . . .

Processing of Claims for Burial Expenses

The Chief Clerk should consider with due care and inspect and examine carefully each funeral bill in each particular situation, not only as to the reasonableness of the amount, but also as to the propriety of every item therein.

Pertinently, the trust relation imposes upon the Statutory Administrator the duty to be bound by the strict rules of fairness for the protection of those whose interests are confined to his care, and to exercise a conscientious regard for matters of benefit to, or the best interests of, the family of the decedent.

Time for Improvement

With complexities of growth and the demands of rapidly changing times, systems and procedures in use often become ineffective or outmoded.

The auditors feel that some revisions, modifications or changes for improvement in the handling of Small Estates could be accomplished by the adoption of simple, reasonable and effective administrative devices.

Consequently, attention is directed to Item III, pages 31 - 34 of the report titled "Proposed System Installations (Small Estates)" which is devoted to some definite proposals in the way of modernizing the existing system and methods of handling the Small Estates, toward promoting better accounting control and greater efficiency.

EXHIBIT "K"

LETTER AND MEMORANDUM OF JUDGE JOHN ALBERT MATTHEWMAN

CIRCUIT COURT OF THE FIRST JUDICIAL CIRCUIT
TERRITORY OF HAWAII

November 13, 1945

Mr. Charles F. Honeywell, Chairman
Territorial Hospital Service Study Commission
With C. Brewer & Company, Limited
Fort & Queen Streets
Honolulu, Hawaii

Sir:

In re "Costs and Services of Burials"

On the telephone I have already informed you of a desire to assist, if I may, in the investigation which your commission will make under Joint Resolution 12 of the Legislature of the Territory of Hawaii, approved May 22, 1945. I am the circuit judge in this circuit who this year is handling small estates. Much dissatisfaction as to the all-devouring charges of some of the funeral parlors came to a climax the early part of the year and naturally I am in a position to inform you as to just what has happened in connection with those charges.

You will find my summary of the matter in the accompanying "Memo by Judge Matthewman".

Respectfully,

(s) John Albert Matthewman

John Albert Matthewman
Fifth Judge of the Circuit Court
of the First Judicial Circuit
of the Territory of Hawaii

MEMO BY JUDGE MATTHEWMAN ON CITY AND COUNTY AUDITOR'S REPORT

There are three sentences on page 23 of the Auditor's report that are decidedly misleading. They appear to have been inserted in the report after the original draft had been perused and criticized by Mr. Restarick. They show his influence, easily recognizable by me.

The first is, "A definite need of policy exists for fixing some practical standard by proper authority in respect to the reasonableness of necessary funeral expenses." For certainly the most of this year a definite policy has been followed by me -- whenever there has come before me what seemed to be an exorbitant charge for funeral services -- and, after full inquiry as to the decedent's status in life, etc., I have determined what was a charge allowable under all the circum-

stances. While $300 has not been fixed as a maximum in all situations, it has so happened that $300 has been the maximum generally allowed, for there is a marked similarity in these small estates, especially those of the Filipinos. Without question I have followed -- under established law as to the rights and duties of a probate judge -- a definite policy.

The second misleading sentence is, "So far as can be foreseen, legislation should be sought to make the necessary funeral expenses of a decedent (Small Estate) a preferred claim only to a certain reasonably fixed amount." No legislation is necessary, although both Mr. Restarick and Mr. Silva -- nearly always conspicuous in these matters as the representative of Silva's Undertaking Establishment and one who formerly was a member of the City and County Civil Service Commission and now is a member of the Territorial Civil Service Commission, both of which commissions have had something to do with our small estate problems -- have urged, and still urge, that, as there is no specific statute covering funeral expenses, the probate judge has no authority whatever to pass upon them.

Small estates were handled in 1943 by Judge Buck, in 1944 by Judge Cristy, and in 1945 they have come before me as the judge assigned to preside in equity and probate matters. At the outset I expressed in open court my astonishment at the all-devouring charges of the undertakers. Mr. Restarick pressed upon me the view that the amounts of those charges were of no concern to the judge, there being no specific statute on the subject. I then asked three members of the bar to act as amici curiae and ascertain whether or not it is so -- as I thought -- that a probate judge has inherent power, without special legislation, to pass upon funeral charges. The attorneys were James M. Richmond, Richard D. Welsh, and Sau Ung Chan. They, separately acting, did excellent work and each advised that undoubtedly the probate judge inherently possesses that power. I thereupon announced my determination to carefully scrutinize such charges. Mr. Restarick protested that other judges had allowed these things to pass and therefore it was not fair to immediately check him in the practice he had been following of paying the large funeral bills. In support of his argument he presented me a list of payments showing what Judges Buck and Cristy had approved. (That list is hereto appended, marked Exhibit A.) Impressed by that argument, I then announced that I would not surcharge Mr. Restarick in those estates where he, relying upon past practice, had already paid large funeral charges, but that he and the undertakers should take notice that surcharges were likely to be made later if the bad practice continued -- that, whatever other judges had done or failed to do, I would not tolerate the payment of exorbitant funeral charges in the small estates. (Large payments not surcharged by me because actually made before my warning are shown in a list hereto appended, marked Exhibit B.)

The third misleading sentence hereinabove mentioned reads, "Undertakers could then be adequately warned that claims exceeding the limitation would probably have to be paid other than from the Small Estates." From the foregoing it should be apparent that the undertakers already have been "adequately warned."

A small estate arresting attention was that of Rio Padron, handled by Judge Cristy last year. Then Richard D. Welsh, representing the Alien Property Custodian and looking out for heirs in the Philippines, urged that in most, although not all, small estates about $300 represents a fair maximum charge for funeral expenses. In that estate the bill of Silva's Undertaking Establishment was for $600. On that there was paid, from outside sources, $200, leaving $400 which the estate was asked to pay. Judge Cristy ruled that, as $200 already had been paid the undertakers, they should be satisfied with $150 more -- which the undertakers refused to accept. There was a definite ruling by Judge Cristy, under the inherent authority of a probate judge, that an exorbitant funeral charge would be cut down, statute or no statute.

The last small estate involving a dispute as to an undertaker's bill coming to the attention of the court before the present confinement of Chief Clerk Restarick in the hospital was that of Raymond N. K. Look. In the matter Judge Matthewman refused to give court approval to a bill of Silva's Undertaking Establishment for $844, ruling that $300 was enough. The Chief Clerk made an unsuccessful effort to have the mother on the witness stand promise to be personally liable for the difference, $544.00, he, Restarick, asserting, "Well, somebody has to see that the undertaker is paid." Restarick is always solicitous for the undertakers.

This funeral bills subject -- sometimes referred to as the Restarick - Silva matter -- has received the attention of Governor Stainback who saw fit to refer it to the Bar Association and to Attorney General Tavares. The latter has assigned his assistant, Edward Z. Buck, to investigate the situation as to the Chief Clerk and funeral expenses in small estates. The matter is also being looked into by a commission appointed by Governor Stainback, pursuant to a Joint Resolution of the last legislature for the investigation of hospital and funeral charges. The chair-

man of that commission is Charles F. Honeywell.

The ramifications of the Restarick-Silva matter have gone so far that pressure had to be exerted to bring Louis K. Silva -- of Silva's Undertaking Establishment and a member of the Territorial Civil Service Commission -- to join with the other members of that commission, Erick H. George and Alfred C. Young, in giving a hearing to the five circuit judges upon the question of compensating the present legal assistant in the Chief Clerk's office, the individual who has brought to the fore the practice of paying very large funeral bills in small estates. At the hearing, belatedly had on October 29, Judge Matthewman successfully challenged the propriety of Silva sitting in judgment upon a matter involving funeral bills and the letter withdrew.

(A list of cases where my fixed stand on exorbitant funeral charges either brought about payments by Mr. Restarick of smaller amounts without special court rulings or where there were specific court rulings against such charges is hereto appended marked Exhibit C.)

EXHIBIT (A)

S.E. NO.	NAME	JUDGE	AMOUNT OF BILL	AMOUNT PAID
3019	John Frias	Buck	$ 730.00	$ 635.00
3025	J. G. Peters, Sr.	Buck	386.00	In Full
3026	S. Oura	Buck	345.00	307.00
3028	Y. Kai	Buck	382.00	248.00
3033	Au Yen	Buck	377.00	349.00
3034	S. R. Stone	Buck	800.00	650.00
3035	R. A. Nui	Buck	612.00	562.00
3037	I. Solomon	Buck	765.00	578.00
Alien Property Custodian interested:				
3360	T. T. Lagandoza	Cristy	378.00	In Full
3382	J. Balisacan	Cristy	412.00	In Full
3397	M. Estrada	Cristy	454.00	In Full
3198	D. Ortiga	Cristy	430.00	In Full
3284	H. Espinda	Cristy	611.00	516.00
3294	William D. Low	Cristy	631.00	In Full
3325	Ting Choy	Cristy	787.00	557.00
3349	C. Saguiad	Cristy	763.00	507.00
3369	H. Uyeno	Cristy	593.00	544.00
3370	Joe Rodrigues	Cristy	708.00	In Full
3365	Manuel Robello	Cristy	850.00	214.00

EXHIBIT (B)

Estate of JOHN J. MEDEIROS, deceased — S. E. No. 3354

Borthwick Funeral Parlor Claim ---------- $377.00
Paid Borthwick Funeral Parlor on Claim ---------- 377.00

Approved May 15, 1945

Estate of HENRY F. SILVA, deceased — S. E. No. 3447

Claim of widow for funeral expenses advanced to Borthwick Funeral Parlors ---------- $407.00

Paid widow on claim ---------- 407.00

Approved February 6, 1945

Estate of WILLIAM K. NOTLEY, deceased — S. E. No. 3493

Claim of Nuuanu Funeral Parlors ---------- $973.00
Paid to Nuuanu Funeral Parlors ---------- 557.89
(balance of assets of estate.)

Approved May 8, 1945

Estate of WILLIAM BARNHARDT WILLING, deceased — S. E. No. 3509

Borthwick Funeral Parlor bill ---------- $479.00
Paid Borthwick Funeral Parlor ---------- 380.00

Pending

EXHIBIT (C)

Estate of Shiro Oshiro — S. E. No. 3514

Claim of Seiki Oshiro - funeral expenses advanced to Kukui Mortuary ---------- $342.00

Paid Seiki Oshiro on Claim ---------- $245.61
(balance of assets of estate).

Approved: July 17, 1945

Estate of Chow Lum Shee — S. E. No. 3570

Nuuanu Funeral Parlor Claim ---------- $803.00
Paid Nuuanu Funeral Parlor ---------- 300.00

Approved September 4, 1945

Estate of Alice Mun Oi Akioka — S. E. No. 3573

Borthwick Funeral Parlors Claim ---------- $380.00
Paid Borthwick Funeral Parlors ---------- $261.37
(balance of assets of estate).

Approved October 2, 1945

Estate of William M. Bibilone, aka William Mabuting Bibilone — S. E. No. 3439

Nuuanu Funeral Parlors Claim ---------- $428.00
Paid Nuuanu Funeral Parlors ---------- $300.00

Approved July 17, 1945

Estate of Carl Joseph Scheid — S. E. No. 3537

Claim of Cooke Trust Co., Ltd., as attorney in fact for Thomas McVeagh for funeral expenses advanced to Borthwick Funeral Parlors ---------- $329.00

Paid Cooke Trust Co., Ltd., on claim ---------- $329.00

Approved August 21, 1945

Estate of Homer K. Leong — S. E. No. 3581

Claim of Nuuanu Funeral Parlors ---------- $643.00
Paid Nuuanu Funeral Parlors ---------- $300.00

Approved October 2, 1945

Estate of Charles W. Neal — S. E. No. 3480

Claim of Viva Neal for payment of funeral expenses advanced to Nuuanu Funeral Parlors ---------- $543.00

Amended claim of Viva Neal for payment of funeral expenses advanced to Nuuanu Funeral Parlors ---------- $370.00

Paid Viva Neal on Claim ---------- $369.54 (balance of assets of estate).

Approved July 10, 1945

Estate of Mae S. Watanabe — S. E. No. 3508

Claim of Takeshi Watanabe for payment of Funeral expenses advanced to Kukui Mortuary ---------- $789.90

Paid Takeshi Watanabe on Claim ---------- $201.48 (balance of assets of estate).

Approved July 3, 1945

Estate of Poli Jones — S. E. No. 3525

Claim of Silva's Undertaking Parlors ---------- $725.00
Paid Silva's Undertaking Parlors ---------- $132.61

Pending for other matters

Estate of Zachary N. Naone — S. E. No. 3372

Claim of Joseph Naone for payment of funeral expenses advanced to Borthwick Funeral Parlors ---------- $775.00

Paid Joseph Naone on Claim ---------- $157.48 (balance of assets of estate).

Pending

Estate of George H. Ikeda — S. E. No. 3502

Claim of Sadaki Ikeda for payment of funeral expenses advanced to Kukui Mortuary, Ltd. ---------- $557.60

Payment in full of claim was disapproved by the court.

Estate of Raymond N. K. Look — S. E. No. 3567

Claim of Silva's Undertaking Establishment ---------- $844.00

Court ordered payment of $300 in full settlement of claim.

Silva's Undertaking Establishment refused to accept payment of $300.

Pending

Estate of Chang Pui — S. E. No. 3355

Claim of Barbara Chang for payment of funeral expenses advanced to Nuuanu Funeral Parlors ---------- $542.00

Paid Barbara Chang on Claim ---------- $145.50 (balance of assets of estate).

Approved September 25, 1945

EXHIBIT "L"

LETTER OF JAMES M. RICHMOND

March 19, 1946

Mr. Gilbert G. Lentz
Secretary, Hospital Service Study Commission
P. O. Box 4067
Honolulu 2, T. H.

Dear Sir:

This will acknowledge receipt of your letter of March 1, 1946, with enclosures. I do not have available at present copies of the various reports filed by me as Master in connection with estates of decedents in the process of settlement in the First Circuit Court. However, as I understand it, the Commission is currently considering the desirability of legislation restricting the amount of funeral expenses chargeable against estates which are administered under our laws as small estates. All of the above reports dealt with estates which were not small estates.

I am happy, however, to give you my comment on the situation, together with my understanding of applicable principles of common law which are involved.

It is well settled that a person's estate is liable for the expense of his burial. 21 Am Jur. 568-9. 34 C.J.S. 135-137. This common law rule is the obvious result of the necessities of the situation created when a person dies. It is equally well settled that the cost and amount of funeral expenses allowable against the estate should be reasonable and correspond to the circumstances and social condition of decedent, including his station in life and the amount of his estate. See 34 C.J.S. 137, n. 68 and cases there cited; 21 Am. Jur. 571, n. 8, and cases there cited. The determination of the proper amount under all the circumstances rests with the probate judge, and he has the power to disallow amounts he determines to be excessive. See In re Allen's Estate, 59 P. (2d) 360 (Wash.); In re Kelly's Estate, 198 N. W. 280 (wis.); In re Throckmorton's Estate, 36 N. E. (2d) 792 (Ohio); In re Bigler's Estate, 35 N.Y.S. (2d) 658, and cases above cited.

As a consequence of the foregoing, there is no technical need for statutory authority to give our probate judges power to disallow as an estate funeral expenses which under all the circumstances are found to be excessive.

However, the fact that no technical lack of power exists on the part of the judges to deal with the situation is not, in my opinion, decisive of whether or not legislation is desirable. This is solely a question of policy. In favor of no legislation, it may be said that the present system has a desirable flexibility, the judge being enabled to deal with each case on its own facts. On the other hand, legislation fixing a limit on funeral expenses chargeable against an estate, at least for small estates, would have the advantage of uniformity as opposed to the varying disprobate bench. It should be borne in mind that the probate calendar shifts at least once a year. Further, as a practical matter, a legislative rule would have greater notoriery than a judicial rule and would have its greatest impact in preventing cases of excessive charges from arising rather than in furnishing a means of dealing with them. In my opinion, legislation is desirable.

It should be noted that the authorities and comment above do not deal with the situation of charges by undertakers in excess of their real value. In such case it is the duty of the executor or administrator to reject the amount claimed as funeral expense, leaving the claimant to his remedy of suit against the estate. In such case the question determined will be the reasonable value of the funeral services, an entirely different question from the question of what is a reasonable amount for a particular estate to bear as funeral expense. For the legislature to attempt to enter this field would simply be a matter of price control. The validity of such legislation would be very questionable, as would its desirability as a matter of policy.

Very truly yours,

(signed) James M. Richmond

JAMES M. RICHMOND

EXHIBIT "M"

"HOSPITAL SURVEY AND CONSTRUCTION ACT"

Following is a summary of the "Hospital Survey and Construction Act", as reported to the Senate by the Senate Committee on Education and Labor.

Purpose: This Act provides a program of federal grants-in-aid to assist the states:

1. To determine their hospital and public health facility needs through statewide surveys.

2. To develop statewide programs for construction of facilities needed to supplement existing facilities so as to furnish adequate hospital, clinic, and other similar services to all the people of the state.

3. To construct such facilities for public and voluntary non-profit hospitals and for public health centers in accordance with such programs.

The term "state" includes Alaska, Hawaii, Puerto Rico, and the District of Columbia.

"Hospital" Broadly Defined: The kinds of facilities which could be constructed under this program include:

1. Public health centers - which are defined to mean a publicly owned facility for the provision of public health services, the scope of which would be a matter for determination by state law.

2. Hospitals - general, tuberculosis, mental, chronic disease, and other types except those furnishing primarily domiciliary care.

3. Related facilities such as laboratories, out-patient departments, nurses' home and training facilities, and central service facilities operated in connection with hospitals.

"Construction" Defined: As used in this Act, the term "construction" is also broadly defined to include:

1. Construction of new buildings.

2. Expansion, remodeling, and alteration of existing buildings.

3. Initial equipment of such buildings.

4. Landscaping the site, architects' fees, legal counsel, and all other expenses incidental to construction excluding:

    a. the cost of off-site improvements, and

    b. except in the case of public health centers, the cost of acquisition of land.

The "cost of construction" would mean the amount found necessary by the Surgeon General for the construction of a project.

Administration: The federal administration of this program would be the responsibility of the Surgeon General of the United States Public Health Service, who would have the assistance of a Federal Hospital Council. This Council, consisting of the Surgeon General and 8 members appointed by the Federal Security Administrator, would share responsibility with the Surgeon General in the formulation of general regulations establishing standards for state construction plans. The Council would also constitute the appeals body in the event a state agency requested a hearing following the Surgeon General's disapproval of a state construction plan, and is empowered to reverse his decisions. The Council's other functions would be advisory. Five of the 8 appointed members would be persons outstanding in fields pertaining to hospital and health activities, and 3 of these

5 would be authorities in matters relating to the operation of hospitals. The other 3 appointed members would represent consumers of hospital services and would be persons familiar with the need of hospital service in urban or rural areas.

Conference of State Agencies: The Surgeon General is required to call an annual conference of representatives of all state agencies participating in the program. Upon the request of 5 or more such state agencies, he would be required to call a conference of representatives of all state agencies joining in the request. He may also call such additional conferences as he feels necessary.

Cooperation With Other Federal Agencies: With the approval of the Federal Security Administrator, the Surgeon General would be authorized to utilize the services and facilities of other federal agencies in accordance with agreements with them.

Surveys and Planning

Appropriation: For surveying and planning to meet the need for additional hospitals and health centers, an appropriation of $5,000,000 is authorized.

State Applications: In order to qualify for a federal grant for purposes of surveying and planning to meet the need for additional hospitals and health centers, a state must have an application approved by the Surgeon General. He is required to approve any application for survey and planning funds which complies with these conditions:

1. It must designate a single state agency to conduct a statewide survey and prepare a statewide program of construction.

2. It must provide for a state advisory council representative of both nongovernment and government groups concerned with the operation, construction, use, and need of hospitals.

3. It must provide for making an inventory and survey, and preparing reports containing information required by the Surgeon General.

Allotments: The $5,000,000 appropriation would be allotted among the states on a population basis. No state, however, would be allotted less than $10,000. Within their allotments the states which have applications approved would be entitled to receive 50% of their expenditures in carrying out their surveys and planning.

Construction of Hospitals and Related Facilities

Appropriation: For the construction of public health centers, hospitals and related facilities, annual appropriations of $75,000,000 are authorized for each of the five fiscal years 1947 to 1951, inclusive.

General Regulations: Within 6 months after the enactment of the Act the Surgeon General, with the approval of the Federal Hospital Council and the Security Administrator, would promulgate general regulations on specified matters referred to below. These regulations are largely concerned with the number and general manner of distribution of hospitals to be constructed under the program.

1. In the case of general hospitals, the distribution is intended to recognize base areas, intermediate areas, and rural areas, and the regulations would prescribe methods by which beds would be distributed among such areas in any state. An overall limitation for purposes of this program, would be $4\frac{1}{2}$ beds per thousand population, except that higher figures (up to $5\frac{1}{2}$ beds per thousand population) would be permitted in sparsely populated states.

2. The limitation upon other hospitals would be as follows:

   a. In the case of tuberculosis, $2\frac{1}{2}$ times the annual average deaths from the cause.

   b. In the case of mental hospitals, 5 beds per 1,000 population.

   c. In the case of chronic disease hospitals, 2 beds per 1,000 population.

3. The limitation on public health centers would be 1 per 30,000 population.

4. Regulations are also authorized prescribing the manner in which the state agency must determine the priority of projects within the state, based upon the relative need of different sections of the population and of different areas lacking adequate facilities, with special consideration to be given hospitals serving rural communities and areas with relatively small financial resources.

5. Regulations are also authorized covering general standards of construction and equipment.

6. The regulations would require that the state plan provide for adequate hospital facilities for the people of the state:

    a. Without discrimination on account of race, creed, or color; and

    b. for persons unable to pay

    Such regulations may require that an applicant for an individual hospital construction project give assurance to the state that it will serve all persons residing in the territorial area of the applicant, but an exception must be made where separate hospital facilities are provided for separate population groups if the state construction plan makes equitable provision on the basis of need for facilities and services of like quality for each such group. The regulations may also require that an applicant give assurance to the state that it will furnish a reasonable volume of hospital services to persons unable to pay, unless the hospital is financially unable to undertake such a commitment.

7. Finally, provision is made for regulations prescribing the general methods of administration of the state plan to construct public and other non-profit hospitals. This authorization relates solely to the administration of the construction program by the state agency, and does not in any way relate to the administration of hospitals constructed under the program.

State Plans: In order to obtain federal funds for the construction of hospitals under this Act, a state would be required to formulate and have approved by the Surgeon General a state plan. Such state plan must:

1. Designate a single state agency to administer or supervise the administration of the construction program.

2. Demonstrate that the state agency so designated will have the necessary authority to carry out the plan.

3. Provide for a state advisory council - representative of nongovernment as well as government groups concerned with the operation, construction, use, and need of hospitals - to consult with the state agency in carrying out the plan.

4. Set forth a hospital construction program based on a statewide inventory of existing hospitals and survey of need, which conforms to the regulations promulgated by the Surgeon General.

5. Set forth the relative need for the individual projects included in the plan, and provide for their construction (insofar as financial resources available for construction and for maintenance and operation permit) in the order of the relative need determined in accordance with regulations prescribed by the Surgeon General.

6. Provide such methods of administration of the state plan as the Surgeon General by regulation requires except that he shall exercise no authority with respect to the selection, tenure of office, or compensation of persons employed by the state agency.

7. Provide minimum standards for the maintenance and operation of hospitals which receive federal aid under this plan. This would be a matter entirely for determination by the respective states. Each state must, prior to July 1, 1947, enact legislation establishing minimum standards for the maintenance and operation of hospitals which shall have received aid under this bill. Questions such as the place of osteopathy in general hospital service would be determined by state law. Any state failing to enact such legislation would be deprived of further allotments under the bill.

8. Provide for affording to applicants for a construction project an opportunity for hearing before the state agency.

9. Submit reports and information required by the Surgeon General.

10. Provide for the review by the state agency of the construction program contained in the plan and submit modification which it considers necessary to the Surgeon General.

The Surgeon General would be required to approve any state plan which complies with the above conditions. In any case in which the Surgeon General disapproves a plan, the Federal Hospital Council must afford the state agency an opportunity for hearing. If the Council determines that the state plan complies with such requirements the Surgeon General must approve the plan.

Project Applications: For each project for construction pursuant to an approved state plan, an application must be submitted to the Surgeon General through the state agency. Such application may be made by the state or a political subdivision thereof or by a public or other nonprofit agency. Such application must set forth:

1. A description of the site and reasonable assurance as to its title.

2. Plans and specifications complying with federal regulations.

3. Reasonable assurance of adequate financial support both for construction and for maintenance and operation of the hospital when completed.

4. Reasonable assurance of the payment of prevailing wages for construction work.

Approval of Projects: The Surgeon General would be required to approve any application which contains the required information and assurances as to title, financial support, and payment of prevailing rates of wages, provided that:

1. Funds to pay the "federal percentage" of the cost are available from the state's allotment.

2. The application conforms to the approved state plan and gives assurance of compliance with requirements of the plan and regulations concerning the availability of hospital services and of compliance with state standards for operation and maintenance.

3. The application has been recommended by the state agency and is entitled to priority in accordance with federal regulations.

No application may be disapproved until the Surgeon General has afforded the applicant and the state agency an opportunity for a hearing.

Allotments: The $75,000,000 annual appropriation for construction would be allotted on the basis of a formula which leaves no administrative discretion in its application. This formula is based on the factors of population and per capita income of the states with extra weight given to the index of financial capacity. For each state there would be determined a "federal percentage" which would be used as a factor:

1. in determining the allotments as among the states, and

2. to fix the proportion of the cost of individual projects in the respective states which would be paid from federal funds.

The attached table shows how the $75,000,000 construction appropriation would be distributed among the states. The proportion of construction costs of individual projects in a particular state which would be met by federal funds would depend upon the per capita income of the state. For example, a state with a per capita income equal to the national average would have a "federal percentage" of 50, and would therefore have to furnish from state or local sources ½ the cost of each construction project within the state. The range of "federal percentages" would vary from 75% for the poorest states to 33 1/3% for the wealthiest states. The federal percentages for each state are also given in the attached table.

Payments: Federal payments would be made to the state agency for transmission to the applicant.

However, if the state agency is legally unable to make payments to any particular applicant, payment would be made by the federal government directly to the applicant.

Withholding of Federal Funds: After notice and opportunity for hearings, the Surgeon General may withhold federal payments if he finds:

1. A state agency is not complying substantially with the required provisions of an application for survey funds.

2. A state agency is not complying substantially with the required provisions of the state plan for the construction of hospitals.

3. Funds have been diverted from the purposes for which they were allotted or paid.

4. Any assurance given in an application is not being or cannot be carried out.

5. There is a substantial failure to comply with approved plans and specifications.

The withholding may be of all funds otherwise payable to the state or on account of projects within the state, or it may be limited to a particular project or projects, depending upon the nature of the default. The Surgeon General's action in both withholding funds or refusing to approve an application for construction funds would be subject to an appeal to the United States Circuit Court of Appeals.

NOTE:

See following page for table illustrating federal matching percentages, annual allotments of federal grants, nonfederal expenditures, and total expenditures for hospital construction, by states, as reported.

States arrayed by per capita income	1942-44 per capita income	Federal percentage	Federal Allotment	Nonfederal funds*	Total funds	
					Amount	Per inhabitant
U.S.	$1,005		$75,000,000	$64,178,000	$139,178,000	$1.04
Connecticut	1,431	33 1/3	404,000	808,000	1,212,000	.68
Nevada	1,372	33 1/3	35,000	70,000	105,000	.68
California	1,366	33 1/3	1,990,000	3,980,000	5,970,000	.68
New York	1,343	33 1/3	2,873,000	5,746,000	8,619,000	.68
Washington	1,336	34	487,000	945,000	1,432,000	.70
Delaware	1,287	36	.75,000	134,000	209,000	.74
New Jersey	1,261	37	1,169,000	1,990,000	3,159,000	.76
D. C.	1,254	38	274,000	447,000	721,000	.78
Oregon	1,204	40	398,000	596,000	994,000	.82
Rhode Island	1,198	40	255,000	383,000	638,000	.82
Michigan	1,183	41	1,869,000	2,690,000	4,559,000	.84
Massachusetts	1,177	41	1,433,000	2,061,000	3,494,000	.84
Illinois	1,175	42	2,791,000	3,855,000	6,646,000	.86
Maryland	1,169	42	769,000	1,062,000	1,831,000	.86
Ohio	1,167	42	2,469,000	3,410,000	5,879,000	.86
Pennyslvania	1,048	48	4,361,000	4,725,000	9,086,000	.98
Indiana	1,040	48	1,613,000	1,748,000	3,361,000	.98
Montana	1,008	50	238,000	238,000	476,000	1.02
Utah	972	52	336,000	311,000	647,000	1.07
Maine	968	52	440,000	406,000	846,000	1.07
Wisconsin	966	52	1,648,000	1,521,000	3,169,000	1.07
Kansas	961	52	983,000	907,000	1,890,000	1.07
Iowa	936	53	1,305,000	1,157,000	2,462,000	1.09
Colorado	935	53	660,000	585,000	1,245,000	1.09
Wyoming	934	54	154,000	131,000	285,000	1.11
Idaho	930	54	317,000	270,000	587,000	1.11
Nebraska	920	54	725,000	617,000	1,342,000	1.11
Missouri	885	56	2,305,000	1,811,000	4,116,000	1.15
Minnesota	876	56	1,610,000	1,265,000	2,875,000	1.15
North Dakota	872	57	351,000	265,000	616,000	1.17
Vermont	863	57	207,000	156,000	363,000	1.17
Arizona	833	59	455,000	317,000	772,000	1.21
Florida	828	59	1,687,000	1,172,000	2,859,000	1.21
S. Dakota	817	59	398,000	277,000	675,000	1.21
Virginia	814	60	2,358,000	1,572,000	3,930,000	1.23
New Hampshire	804	60	337,000	224,000	561,000	1.23
Texas	791	61	5,238,000	3,349,000	8,587,000	1.25
Oklahoma	720	64	1,732,000	974,000	2,706,000	1.31
West Virginia	692	66	1,530,000	788,000	2,318,000	1.35
Louisiana	678	66	2,261,000	1,165,000	3,426,000	1.35
New Mexico	660	67	489,000	241,000	730,000	1.37
Tennessee	645	68	2,717,000	1,279,000	3,996,000	1.39
Georgia	624	69	3,142,000	1,412,000	4,554,000	1.41
N. Carolina	606	70	3,546,000	1,520,000	5,066,000	1.43
Kentucky	589	71	2,714,000	1,109,000	3,823,000	1.46
Alabama	579	71	2,908,000	1,188,000	4,096,000	1.46
S. Carolina	560	72	2,041,000	794,000	2,835,000	1.48
Arkansas	522	74	1,991,000	700,000	2,691,000	1.52
Mississippi	468	75	2,506,000	835,000	3,341,000	1.54
Alaska	---	50	37,000	37,000	74,000	1.02
Hawaii	---	50	217,000	217,000	434,000	1.02
Puerto Rico	---	75	2,152,000	718,000	2,870,000	1.54

*Represents state, local, and private funds which must be expended to take up entire federal allotment in preceding column.

EXHIBIT "N"

SESSION LAWS 1945
TERRITORY OF HAWAII

JOINT RESOLUTION NO. 12

CREATING A TERRITORIAL HOSPITAL SERVICE STUDY COMMISSION, PRESCRIBING ITS POWERS AND DUTIES, AND THOSE OF THE LEGISLATIVE REFERENCE BUREAU, CONCERNING A STUDY AND REPORT ON HOSPITAL SERVICES AND COSTS AND A STUDY AND REPORT ON BURIALS AND COSTS AND THE FEASIBILITY AND COST OF ESTABLISHING A TERRITORIAL SYSTEM OF HEALTH INSURANCE AND OF BURIAL INSURANCE, AND MAKING AN APPROPRIATION THEREFOR.

WHEREAS, the maintenance of adequate hospital facilities (including necessary personnel) in constant readiness, and the furnishing of such facilities to the people of the Territory at such individual expenses as will not unduly deter utilization of hospital facilities, are necessary to the public health and welfare; and

WHEREAS, the maintaining in constant readiness of such hospital facilities constitutes a public service of benefit to all residents of the Territory, and the continuing costs of maintaining said facilities should equitably be borne by all persons benefited; and

WHEREAS, it has been proposed that the continuing costs of maintaining necessary hospital facilities in a state of readiness be defrayed out of the public revenues, the costs attributable to the rendition of service to particular patients to be borne by the persons served, and said proposal merits serious study and consideration; and

WHEREAS, by House Bill No. 659, introduced in the Twenty-Third Legislature, it is proposed that there be established in the Territory a system of health insurance, a health insurance commission and a health insurance fund; and

WHEREAS, the costs and services of burials are of vital interest to the health and morale of the community and it has been proposed that there be established and maintained by the Territory a system of burial insurance; now therefore, BE IT ENACTED BY THE LEGISLATURE OF THE TERRITORY OF HAWAII:

SECTION 1. There is hereby created the Territorial Hospital Service Study Commission consisting of seven members who shall be appointed by the governor in the manner prescribed in section 80 of the Organic Act and who shall hold office for a term of two years. Public officers and employees shall be eligible to serve as members of said commission and the governor shall designate one of the members of the commission as chairman thereof. The Director of the Legislative Reference Bureau shall serve as secretary for the commission.

SECTION 2. The members of the commission and the secretary shall serve without pay, but they and their stenographic, clerical and professional assistants shall be entitled to their reasonable and necessary traveling expenses incurred in the discharge of their duties and, when required to travel from any island to another island in the Territory in the performance of such duties, shall be allowed, in addition to transportation fares, ten dollars a day to cover all other expenses.

SECTION 3. The commission is hereby authorized and directed to make a comprehensive study of hospital and burial services and costs in the Territory of Hawaii and to make its report and recommendations for bills or otherwise to the next regular session of the Legislature of the Territory of Hawaii.

SECTION 4. The Legislative Reference Bureau shall collaborate with the commission through a comprehensive study and investigations of all matters relating to hospitals and burials, financing and services, estimates of the cost of prividing and maintaining out of public revenues adequate hospital and burial facilities for the people of the Territory, and the submission to the commission of all data so assembled and such other information and reports as are requested of it by the commission. The Legislative Reference Bureau shall include in its studies the feasibility of establishing a territorial system of health insurance, and shall report all available informa-

tion and data thereon to the commission, which shall render to the next regular session of the Legislature its findings and recommendations thereon. The Legislative Reference Bureau shall assemble and direct such special research and clerical staff as shall be necessary for the foregoing purposes and for which provision is made out of the funds hereinafter appropriated.

SECTION 5. There is hereby appropriated out of the general revenues of the Territory the sum of fifty thousand dollars ($50,000.00), or so much thereof as may be necessary, for the payment of expenses of the commission and for such special research and clerical staffs as it or the Legislative Reference Bureau may need for the purposes of this Joint Resolution. Such sum appropriated shall be disbursed upon vouchers approved by the chairman of the commission.

SECTION 6. This Joint Resolutiin shall take effect upon its approval.

APPROVED this_____day of May, A.D. 1945

(S) INGRAM M. STAINBACK

Governor of the Territory of Hawaii

PART III

PROPOSED BILL

AN ACT

TO ADD TO TITLE 12 OF THE REVISED LAWS OF HAWAII 1945 A NEW CHAPTER PROVIDING A SYSTEM OF ORGANIZED PAYMENT FOR PHYSICIANS' AND HOSPITAL SERVICES RENDERED IN THE CARE OF PATIENTS HOSPITALIZED IN GENERAL OR RELATED HOSPITALS, OR RENDERED IN CONNECTION WITH MATERNITY CASES, AND PROVIDING FOR THE IMPROVEMENT OF HOSPITAL SERVICES, FOR PROFESSIONAL POSTGRADUATE EDUCATION AND FOR PUBLIC EDUCATION FOR THE IMPROVEMENT OF HEALTH; CREATING IN THE TERRITORIAL GOVERNMENT A BOARD OF HOSPITAL AND MEDICAL CARE, AND PRESCRIBING ITS POWERS, DUTIES AND FUNCTIONS; AND PROVIDING FOR THE LEVY AND COLLECTION OF TAXES UPON EMPLOYERS AND UPON INDIVIDUALS, FOR THE DISPOSITION OF THE PROCEEDS OF SUCH TAXES, AND FOR RECOVERABLE ADVANCES FROM THE TERRITORIAL GENERAL FUND TO SUPPLEMENT THE RECEIPTS FROM SUCH TAXES.

BE IT ENACTED BY THE LEGISLATURE OF THE TERRITORY OF HAWAII:

Section 1. There is hereby added to Title 12 of the Revised Laws of Hawaii 1945 a new chapter to be numbered Chapter 85.02, reading as follows:

"CHAPTER 85.02. HOSPITAL AND MEDICAL CARE.

Sec. 4880.01. Findings. It is the intent of the legislature hereby to acknowledge the obligation of the people of this Territory to participate in a system of organized payment for physicians' and hospital services rendered in the care of patients hospitalized in general or related hospitals, or rendered in connection with maternity cases, where such services are not available to the patient in custodial hospitals or otherwise provided by public agencies; and, incidentally to the foregoing primary purpose, to promote improvement of hospital services, to provide for professional postgraduate education, and to provide for public education for the improvement of health. It is declared as a matter of legislative determination that in the absence of an organized system of payment the receipt by individuals and families of hospital and physicians' services for hospitalized illnesses varies, in general, according to ability to pay rather than according to need, to the detriment of the health and welfare of the people of the Territory; that the economic burden of hospitalized illness cannot be predicted for an individual or for a family over a specified period of time, but can be predicted with reasonable accuracy for large groups of individuals and families; that the cost of hospitalized illness lends itself to equitable distribution over groups of individuals and families and over designated periods of time; that the costs of hospitalized illness should be distributed over individuals and families in accordance with their ability to pay, but that care should be provided in accordance with need, without emphasis upon any means test; and that in the establishment of a system of organized payment for hospitalized illness the personnel and institutions furnishing services should be guaranteed adequate remuneration, provision should be made for the continuing education of professional personnel, preventive health services should be emphasized, improvement in the standards and adequacy of institutional facilities should be encouraged, policies concerned with the administration of and payment for medical care should be determined by the joint action of professional, institutional and public representatives, provision should be made for professional administration of professional services, and provision should be

made for continuing studies of the most effective ways to utilize the health facilities of the Territory.

Sec. 4880.02. Definitions. Wherever used in this chapter, unless the subject matter, context or sense otherwise require:

"Board" means the territorial board of hospital and medical care.

"Director" means the director of hospital and medical care and any subordinate duly authorized by him to perform any of the duties and functions imposed upon him by this chapter.

"Hospital" includes a lying-in institution.

"Participating hospital" means a hospital which is a party to a contract with the board for the furnishing of hospital services to insured individuals, to the extent that such hospital shall be rendering services pursuant to such contract.

"Insured individual" means an individual who, during the calendar year last previous to the period of insurance, shall have received wages or net income in the amount of one dollar or over and shall have paid the taxes imposed by this chapter with respect thereto, or who, during at least six months of such previous calendar year, shall have been a dependent of such individual, and, in both cases, who shall have been a resident of the Territory for at least six months of such previous calendar year; and shall also include any child of an insured individual born since the beginning of such calendar year; provided, however, that if any individual shall file with the board a written waiver of the benefits provided under this chapter, pursuant to an election to accept in lieu thereof benefits provided by any other governmental agency or any private agency, such individual and the minor dependents of such individual shall not be eligible for the benefits provided under this chapter during any period of insurance covered by such waiver.

"Dependent" of an individual means any person (other than the spouse of the individual) who is living with and receiving his chief support from such individual, and who is either under the age of eighteen years, under the age of twenty-one years and attending a recognized educational institution, or incapable of self-support because mentally or physically defective; the wife of the individual who is living with such individual or receiving regular support from him; the husband of the individual who is living with such individual and is incapable of self-support because mentally or physically defective; a parent, either of the individual or of the spouse of the individual, who is living with and receiving his chief support from such individual; and any person who is receiving his sole support from such individual, whether or not he is living with such individual.

"Period of insurance", with respect to an insured individual, means the period from the seventh to the eighteenth months, inclusive, following the expiration of the calendar year in which such individual by receipt of wages or net income, or by dependency, shall have acquired such status.

"Resident of the Territory" means an individual who is actually present in the Territory and who is not a mere transient or sojourner therein, or who is domiciled in the Territory and absent therefrom as a mere transient or sojourner elsewhere.

"Physician" means any person licensed under the laws of the Territory to practice medicine or surgery, or otherwise to administer or prescribe the administration of drugs or medicine or to perform surgical operations, while acting within the scope of such license.

"Period of hospitalization" means all time spent as an inmate of a participating hospital during a single period of insurance, occasioned by or incidental to the diagnosis, treatment and care of a single disease, defect or condition, whether or not the days of hospitalization making up such period shall be consecutive.

"Necessary hospital services" means all hospital services determined by a physician, in conformity with standards prescribed by the board, to be required for the proper diagnosis, treatment and care of the patient, and rendered by a participating hospital (a) at any time during the course of a maternity case, or (b) during a period of hospitalization, but not including any services rendered during the first five days thereof unless the hospitalization is in the course of a maternity case or occasioned by the performance of a surgical operation, and not including services rendered subsequent to the expiration of the thirtieth day thereof; provided, however, that "necessary hospital services" shall not include the furnishing of accommodations more expensive than ward accommodations; and provided further, that if the board shall determine that funds and facilities are available therefor the board may by rule or regulation include within the meaning of "necessary hospital services", for the purposes of this chapter, such services rendered within the first five days of a period of hospitalization as it shall deem desirable for effectuating the purposes of this chapter, and such services rendered after the first thirty days of a period of hospitalization as are essential for the treatment and care of non-chronic injuries or illnesses normally requiring more than thirty days' hospitalization, as determined by the board.

"Necessary medical services" means all services rendered in the hospital by a physician, during the first thirty days of a period of hospitalization of an insured individual, in the diagnosis, treatment and care of a condition determined by a physician, in conformity with standards prescribed by the board, to require hospitalization of the insured individual; provided, however, that if the board shall determine that funds are available therefor the board may by rule or regulation include within the meaning of "necessary medical services", for the purposes of this chapter, such services rendered after the first thirty days of a period of hospitalization as are essential for the treatment and care of non-chronic injuries or illnesses normally requiring more than thirty days' hospitalization, as determined by the board.

"Employer" shall include any individual, person, trust estate, decedent's estate, business trust, corporation, association, joint stock company, partnership or other entity or group employing any person, and shall also include the auditor of the Territory, the auditor of any county and any other officer or agent of the Territory, or any county, charged with the disbursement of public moneys as compensation to employees of the Territory or county, or any department or a-

gency thereof, as the case may be, in so far as such disbursements are concerned.

"Wages" shall mean and include commissions, fees, wages, salaries, bonuses and every and all other kinds of compensation paid by an employer to any resident of the Territory for services performed by such resident as an employee under the direction and control of the employer, not including, however, compensation paid as a pension for past services, and subject also to the exceptions provided by section 4880.13. Perquisites received by any employee, or payments in lieu of perquisites made to an employee, shall not be construed to be "wages" under the provisions of this chapter.

"Perquisites" means living accommodations, board, laundry, fuel, light, heat, medical care, and the like, furnished to an employee by an employer where (1) the furnishing thereof is for the bona fide convenience of the employer (whether or not the furnishing thereof is also an inducement to the employment), and (2) the employee has no election to receive cash payments in lieu thereof. "Payments in lieu of perquisites" refers to payments made at the option of the employer where the employer generally furnishes perquisites to the class of employee involved and the making of payments in lieu thereof is exceptional.

"Net income" means the amount remaining of gross income determined pursuant to sections 5505 and 5507 but subject to the exceptions provided by section 4880.13, after excluding therefrom the items specified in subparagraphs (b), (c), (d), (f), (h), (i), and (j) of section 5506, and all wages, and after deducting therefrom the items specified in subparagraphs (c), (d), (e), (f), (g), (h) and (i) of section 5508.

"Tax commissioner" shall mean and include the tax commissioner of the Territory and any duly appointed subordinate of his department duly authorized by him to perform any of the duties and fuctions imposed upon him by this chapter.

"Collector" shall include the tax commissioner and any tax collector of the Territory.

Sec. 4880.03. Board of hospital and medical care. There is hereby created a board of hospital and medical care, consisting of nine appointive members, of whom two shall be physicians, two shall have had experience in hospital administration as a member of the staff of a hospital, two shall be selected by the Governor as representatives of employers, two shall be selected by the Governor as representatives of employees, and one, who shall be chairman, shall be selected by the Governor as representative of the public; together with the president of the board of health and the director of public welfare, as ex-officio members. The members of the board, other than ex-officio members, shall be appointed and shall be removable in the manner prescribed by the first paragraph of section 80 of the Organic Act, and shall hold office for four years or until their successors are appointed and qualified; provided, that the term of office to which first appointed of one physician, one of the persons experienced in hospital administration, one of the representatives of employers, and one of the representatives of employees shall be two years. Prior to appointing any member of the board who is required to be a physician or to have had experience in hospital administration,

to the extent practicable, the Governor shall give notice to all professional associations which include within their membership persons qualified for such appointment, and shall afford opportunity to each such professional association to recommend individuals for such appointment. Any vacancy shall be filled by appointment for the unexpired term. All of the members of the board shall serve without pay, but shall be reimbursed for their reasonable traveling and other expenses incurred in the discharge of their duties. The chairman shall be the presiding officer of the board. In the absence of the chairman, or in the event of a vacancy in the office of the member selected as representative of the public, the members of the board may designate any member to serve as acting chairman. The board shall meet as often as necessary and at least once in each month, at such other times as it shall determine and at the call of the chairman. Five members of the board shall constitute a quorum for the performance of any duties or for the exercise of any power of the board, but ex-officio members shall not be counted in ascertaining the presence of a quorum.

Sec. 4880.04. Director, assistants and staff. The board shall appoint a director of hospital and medical care, who shall be the executive officer of the board and who shall act as secretary of the board. The director shall have all of the powers and authority, under the direction and control of the board, as shall be necessary for carrying on the executive work of the board, including the control, management and direction of all officers and employees of the board, other than assistant directors, and the appointment, suspension or dismissal of such officers and employees, subject to any applicable civil service and personnel classification laws then in effect. The board may appoint such assistant directors as it shall deem necessary and prescribe their duties and authority. The director and assistant directors shall receive such compensation as the board shall fix, and shall not be subject to any civil service or personnel classification law of the Territory. The director, and the assistant directors within the scope of their duties and authority, shall have the power and duty to administer and enforce all regulations and directions of the board, and the powers and functions which are delegated to the board under the laws of the Territory. Any of the duties, powers and authority of the director and assistant directors, including authority to sign vouchers and make determinations of benefits and services, may be delegated, with the approval of the board, to subordinate officers and employees of the board.

Sec. 4880.05. Hospital and medical care fund; advances and transfers; additional funds. There is hereby created a hospital and medical care fund. Any moneys in the hospital and medical care fund shall be available for expenditure by the board pursuant to this chapter, for any of the purposes herein set forth, and all such moneys are hereby appropriated for such purposes. In the event that at any time there shall be insufficient moneys in the hospital and medical care fund to meet the current needs of the board, the territorial treasurer, with the approval of the governor, may make temporary advances from time to time to said fund from the general fund of the Territory, to be reimbursed to said general fund

thereafter when moneys therefor are available in the hospital and medical care fund, such temporary advances, however, not to exceed at any time such total amount as shall be estimated to be repayable out of the hospital and medical care fund from collections for the next ensuing three months following the month in which the last of such advances was made.

Section 4880.06. Duties and powers of board. In addition to such duties and powers as may be otherwise conferred, the board shall have the following duties and powers:

1. To furnish or cause to be furnished to insured individuals the benefits provided under this chapter for which they shall be eligible.

2. To enter into such contracts with hospitals, upon such terms and conditions as it shall determine, for the payment of the cost of necessary hospital services rendered during a period of insurance for an insured individual, as it shall deem necessary to effectuate the purposes of this chapter, and to determine and prescribe in such contracts, or by rule or regulation, methods and procedures for ascertaining the costs of such services; provided, however, that the board shall not exercise supervision or control over the administration, personnel or operation of a participating hospital, whether by virtue of any term or condition of any such contract or otherwise. The provisions of chapter 9 shall not apply with respect to any such contract.

3. To make rules and regulations prescribing schedules of fees and charges, payable as benefits provided under this chapter, for physicians' services rendered for insured individuals. In prescribing such schedules of fees and charges, the commission shall provide financial incentives for the professional advancement of physicians and encourage high standards in the quality of services rendered to insured individuals.

4. To hear and determine all claims of insured individuals, physicians or hospitals arising under this chapter.

5. To estimate, from time to time, the funds available for the financing of benefits provided under this chapter, and to determine the benefits which may be provided consistently with proper administration of such funds. For all purposes of this chapter, the benefits provided under this chapter shall include only the benefits included within such determination by the board. The board shall be empowered to reduce or increase the period of hospitalization, to alter the nature and extent of services of hospitals and physicians included, and otherwise to expand or diminish the scope of benefits provided under this chapter.

6. To require insured individuals, as a condition to receipt of benefits provided under this chapter, to give such notices, present such evidence of identity and qualification, and observe such procedures as it shall prescribe for the effective administration of this chapter.

7. To carry on research and compile statistics for the purpose of promoting the efficient administration of this chapter and to furnish a factual basis for evaluating the scope of the benefits provided under this chapter, and to report to each legislature its findings and recommendations for achieving the purposes

of this chapter, together with a full account of the administration of this chapter.

8. To appoint advisory committees of professional, employer, employee and public representatives and establish their duties and functions. The members of such advisory committees shall receive no compensation, but shall be reimbursed all expenses incurred.

9. To define all terms used herein; and to make, amend and repeal rules and regulations, having the force and effect of law, necessary or proper to effectuate any of the purposes of this chapter, including rules governing the procedure in hearings, investigations, recording, registration, determination of benefits and services, and the conduct of other activities of the board, but not including, however, rules for the enforcement of the provisions of this chapter relating to the assessment, levy and collection of taxes.

10. To furnish financial or other assistance to the education or training of persons useful to or needed in the furnishing of the hospital and medical care benefits provided under this chapter.

11. To apportion and disburse all moneys in the hospital and medical care fund, or otherwise appropriate for the purposes of this chapter.

12. To supervise and administer any other activities authorized or required by this chapter.

Sec. 4880.07. Records and hearings. The records of the board relating to diagnosis, care and treatment of any individual, except to the extent necessary for the proper administration of this chapter, shall be confidential. It shall be the duty of the board to prescribe by regulation such procedures as are necessary to protect such records from publication or public inspection in any manner revealing the identity of the individual concerned, and to prescribe such procedures for hearings as will prevent, to the extent consistent with proper administration of this chapter, the public disclosure of information relating to the diagnosis, care and treatment of any individual.

Sec. 4880.08. Benefits. Every insured individual, during the period of insurance, shall be eligible for the benefits provided under this chapter. Such benefits, to the extent determined by the board and subject to such rules and regulations as shall be adopted by the board, shall include the following:

1. In the case of an insured individual who received, or acquired such status as the dependent of an individual who received, a total of wages and net income amounting to less than $5000. during the calendar year last previous to the period of insurance, if such calendar year was subsequent to December 31, 1947; or who received, or acquired such status as the dependent of an individual who received, a total of wages and net income amounting to less than $2500. during the period from July 1, 1947 to December 31, 1947, inclusive:

(a) Payment of the cost of necessary hospital services furnished to the insured individual by a participating hospital.

(b) Payment of the cost, not exceeding the amount determined by application of such schedule of fees or charges as shall be prescribed by the board, of all

necessary medical services furnished to the insured individual.

(c) Payment of the cost, not exceeding the amount determined by application of such schedule of fees or charges as shall be prescribed by the board, of all physicians' services and of all necessary hospital services in maternity cases, including antepartum and postpartum care, where the patient shall be the insured individual or the spouse of the insured individual.

2. In the case of an insured individual who received, or acquired such status as the dependent of an individual who received, a total of wages and net income amounting to $5000. or more during the calendar year last previous to the period of insurance, if such calendar year was subsequent to December 31, 1947; or who received, or acquired such status as the dependent of an individual who received, a total of wages and net income amounting to $2500. or more during the period from July 1, 1947 to December 31, 1947, inclusive:

(a) Reimbursement of the cost of necessary hospital services furnished to the insured individual by a participating hospital.

(b) Reimbursement of the cost, not exceeding the amount determined by application of such schedule of fees or charges as shall be prescribed by the board, of all necessary medical services furnished to the insured individual.

(c) Reimbursement of the cost, not exceeding the amount determined by application of such schedule of fees or charges as shall be prescribed by the board, of all physicians' services and of all necessary hospital services in maternity cases, including antepartum and postpartum care, where the patient shall be the insured individual or the spouse of the insured individual.

Nothing herein shall be deemed to prevent the furnishing by any hospital to an insured individual of services in addition to necessary hospital services, or to affect the right of any hospital to require payment with respect to such additional services. In the event that services more expensive than necessary hospital services shall be rendered to an insured individual in substitution for necessary hospital services, payment or reimbursement shall be made of the cost of the necessary hospital services in substitution for which such services shall have been rendered, determined by reference to the costs of rendering such necessary hospital services in the same hospital.

Provided, that the benefits provided under this chapter shall not include payment or reimbursement of the cost of physicians' or hospital services determined by the board to be provided for the insured individual by any other governmental agency, or with respect to which the board shall determine that the insured individual has an enforceable claim for services or indemnification against any private agency or institution.

Sec. 4880.09. Prohibition upon excessive fees. No person shall knowingly exact or attempt to exact from any person a fee or charge for hospital or physicians' services rendered to an insured individual if said services shall have been rendered during the period of insurance of such individual and if the cost of said services shall have been payable as a benefit provided under this chapter. This section shall not be deemed to prohibit the exaction of a fee or charge for serv-

ices rendered in addition to services the cost of which shall have been payable as such benefit, or to prohibit the exaction of a charge or fee for the excess of value of more expensive services rendered in substitution for services the cost of which shall have been so payable. Nothing herein shall be deemed to require the repayment of any fee or charge which shall have been received in good faith.

Sec. 4880.10. Workmen's compensation benefits. Every person required by the provisions of chapter 77 to furnish to an individual medical, surgical or hospital services or supplies, if the cost of such services or supplies shall have been paid or reimbursed as a benefit provided under this chapter, shall promptly pay to the board the amount of all sums so expended by the board. All amounts payable to the board pursuant to this section shall be paid into the hospital and medical care fund. An action may be brought in the name of the Territory, pursuant to section 10484, to recover any amounts so payable. The provisions of this section shall not be interpreted as impairing the right of any individual to receive the benefits provided under this chapter, but the board shall by regulation prescribe procedures applicable to cases covered by this section in order to expedite recovery of amounts payable to the board pursuant to this section and to minimize the costs of administration of this chapter.

Sec. 4880.11. Tax on wages and net income. In addition to other taxes there shall be assessed, levied, collected and paid for each calendar year upon wages and net income of every resident of the Territory, taxes as follows:

(a) Upon all wages received during such calendar year, one and one-fourth per centum (1¼%) of the amount thereof not in excess of $5000.

(b) Upon all net income received during such calendar year, two and one-half percentum (2½%) of the amount thereof not in excess of the amount resulting from the deduction, from the sum of $5000, of the amount of wages received by such individual during such calendar year.

Sec. 4880.12. Tax on employers. In addition to other taxes, every employer shall pay an excise tax, with respect to having individuals in his employ, equal to one and one-fourth percentum (1¼%) of the wages, not exceeding $5000 in each calendar year, paid by such employer to any resident of the Territory.

Sec. 4880.13. Wages and gross income, exceptions. Despite the generality of any other provisions of this chapter, the terms "wages" and "gross income" as used in this chapter shall not include:

(a) Compensation paid to any individual by an employer during any calendar year after wages in the amount of $5000 have been paid to such individual by such employer during such calendar year.

(b) Compensation paid to employees whose need of employment, or of some form of public assistance, has been determined by federal, territorial or county authorities, where it shall appear that the payment of such compensation is a form of public assistance for the relief of need, and that the amount of such compensation is based upon the needs of the persons assisted and not upon the prevailing rate of compensation for the work done.

(c) Any income received by an individual while such individual shall be an

employee of an employer, including the United States or any instrumentality thereof, exempt from the tax imposed upon employers by section 4880.12 of this chapter, unless such employer shall in fact pay such tax with respect to all individuals employed by such employer during the calendar year.

(d) Any income received by an individual during the period from July 1, 1947 to December 31, 1947, inclusive, or during a calendar year subsequent to December 31, 1947, prior to the commencement of which period or calendar year such individual shall have filed with the board, pursuant to regulations prescribed by the board, an affidavit stating that he adheres to the faith or teachings of a recognized religious sect, denomination or organization and, in accordance with its creed, tenets or principles, depends for healing upon prayer in the practice of religion.

(e) Any income received by an individual prior to July 1, 1947.

Sec. 4880.14. Community property law inapplicable. Wages and net income, for the purposes of this chapter, shall be deemed to have been received solely by the individual in whose name the same shall be received, notwithstanding that the same shall be community property of such individual and the spouse of the individual.

Sec. 4880.15. Employer to withhold and pay taxes on wages. Any employer making payments of wages shall deduct and withhold therefrom the amount of the tax imposed by section 4880.11 in reference to such wages and shall pay the amount so withheld for each month, together with the amount of the tax imposed by section 4880.12 with respect to such wages, within twenty days after the close of such month, to the collector of the taxation division in which the employer has his principal place of business, or to the tax commissioner at Honolulu if the employer has no place of business in the Territory; provided, that the tax commissioner may grant permission to make returns and payments on a quarterly basis, as provided, in section 4880.16. Any employer who violates any of the provisions of this section shall be guilty of a misdemeanor and shall also be liable to pay to the Territory the amount which he should have so withheld from the employee; provided, that the employer may recover from such employee any amount which he has been required to pay and has paid to the Territory out of such employer's own funds pursuant to this section.

Sec. 4880.16. Employers returns. (a) Every employer shall, on or before the 20th day of each month, make a full, true and correct return showing all wages paid by him during the preceding month and showing the tax due thereon pursuant to section 4880.12 and the tax required to be withheld thereon pursuant to section 4880.15, which returns shall be filed at the place prescribed in section 4880.15 for payment of the tax and shall include such other information as shall be required or prescribed by the tax commissioner; provided, however, that with respect to wages paid out of public moneys, the tax commissioner in his discretion may prescribe special forms for, and different procedure and times for the filing of such returns by employers paying such wages, or may, upon such conditions and subject to such rules as he may prescribe from time to time, waive the filing of

any such returns; provided, further, that the tax commissioner may grant permission to employers having a pay roll of not more than one thousand two hundred fifty dollars per quarter, to make returns and payments on a quarterly basis, such returns and payments to be made within twenty days after the close of each quarter, to-wit: on or before April 20, July 20, October 20 and January 20.

(b) Every employer required to deduct and withhold any tax on the wages of any employee shall furnish to each such employee in respect of his employment during the calendar year, on or before January 31 of the succeeding year, or, if his employment is terminated before the close of such calendar year, on the day on which the last payment of wages is made, a written statement, showing the period covered by the statement, the wages paid by the employer to such employee during such period, and the amount of the tax deducted and withheld or paid in respect of such wages. Each such employer shall include with his final return for the calendar year, or shall file on or before January 31, a duplicate copy of each such statement. The tax commissioner may grant to any employer a reasonable extension of time, not in excess of sixty days, with respect to any statement required by this subsection to be furnished to an employee or filed, and may by regulation provide for the furnishing or filing of statements at such other times and containing such other information, as may be required for the administration of this chapter. The tax commissioner shall prescribe the form of the statement required by this subsection and may adopt any federal form appropriate for the purpose.

Sec. 4880.17. Taxes withheld by employer held in trust. All taxes withheld by any employer under section 4880.15 shall be held in trust by him for the Territory and for the payment of the same to the collector in the manner and at the times required by this chapter.

Sec. 4880.18. No cause of action against employer for withholding. No employee shall have any right of action against his employer in respect of any moneys deducted from such employee's wages in compliance or intended compliance with this chapter.

Sec. 4880.19. Payment of tax on net income. The tax imposed by this chapter on net income shall be due on January 1 and payable on March 20 following the close of the calendar year.

Sec. 4880.20. Returns. Every individual having net income for the calendar year of one dollar or over shall make a return which shall be authenticated by the signature of the individual or his authorized agent under the penalties provided by section 5134, stating specifically the items of his gross income and the exclusions and deductions allowed under this chapter. Returns shall be made and filed on or before March 20 following the close of the calendar year. The tax commissioner may grant a reasonable extension of time for making and filing returns under such rules and regulations as he shall prescribe, whenever he shall find that delay in the filing of such returns will not interfere with the administration of this chapter.

Sec. 4880.21. Other provisions applicable. The provisions of section 5510,

5511, 5512, 5514 and 5515 shall be applicable to the determination of the net income of an individual for the purposes of this chapter, and the term "taxable year" as used therein shall be deemed to refer to the calendar year. All other provisions of Chapter 102 not inconsistent with the provisions of this chapter and which may appropriately be applied to the taxes, persons, circumstances and situations covered or affected by this chapter, including provisions granting administrative powers to the tax commissioner and providing for the assessment, levy and collection of income taxes, shall be applicable to the assessment, levy and collection of taxes under this chapter. The provisions of section 5517, and any amendments thereof, with respect to penalties and interest, shall apply to the taxes imposed by this chapter.

Sec. 4880.22. Refunds and disposition of proceeds.

(a) If by reason of an individual receiving wages from more than one employer during a calendar year, the wages received by him during such calendar year shall exceed $5000, the individual shall be entitled to a refund of any amount of the tax imposed by section 4880.11 upon such wages and withheld from wages payable to the individual by an employer (whether or not paid to the Territory) which exceeds the sum of $62.50. If it shall be shown that there has been withheld from wages payable to an individual any tax not due thereon or more than the amount of tax due thereon, the amount found to have been overpaid or otherwise not due shall be refunded to the individual, if the tax commissioner shall be satisfied that the amount so overpaid or otherwise not due has been paid to the Territory. Such refunds shall be made out of current collections of the taxes imposed by this chapter, and payment thereof shall be made only if application for such refund shall be filed with the tax commissioner after the end of the calendar year in which the amount to be refunded was withheld and prior to the expiration of six months after the end of such calendar year.

(b) The net collections of the taxes imposed by this chapter, remaining after the refunds authorized by law, shall be paid into the hospital and medical care fund created by this chapter.

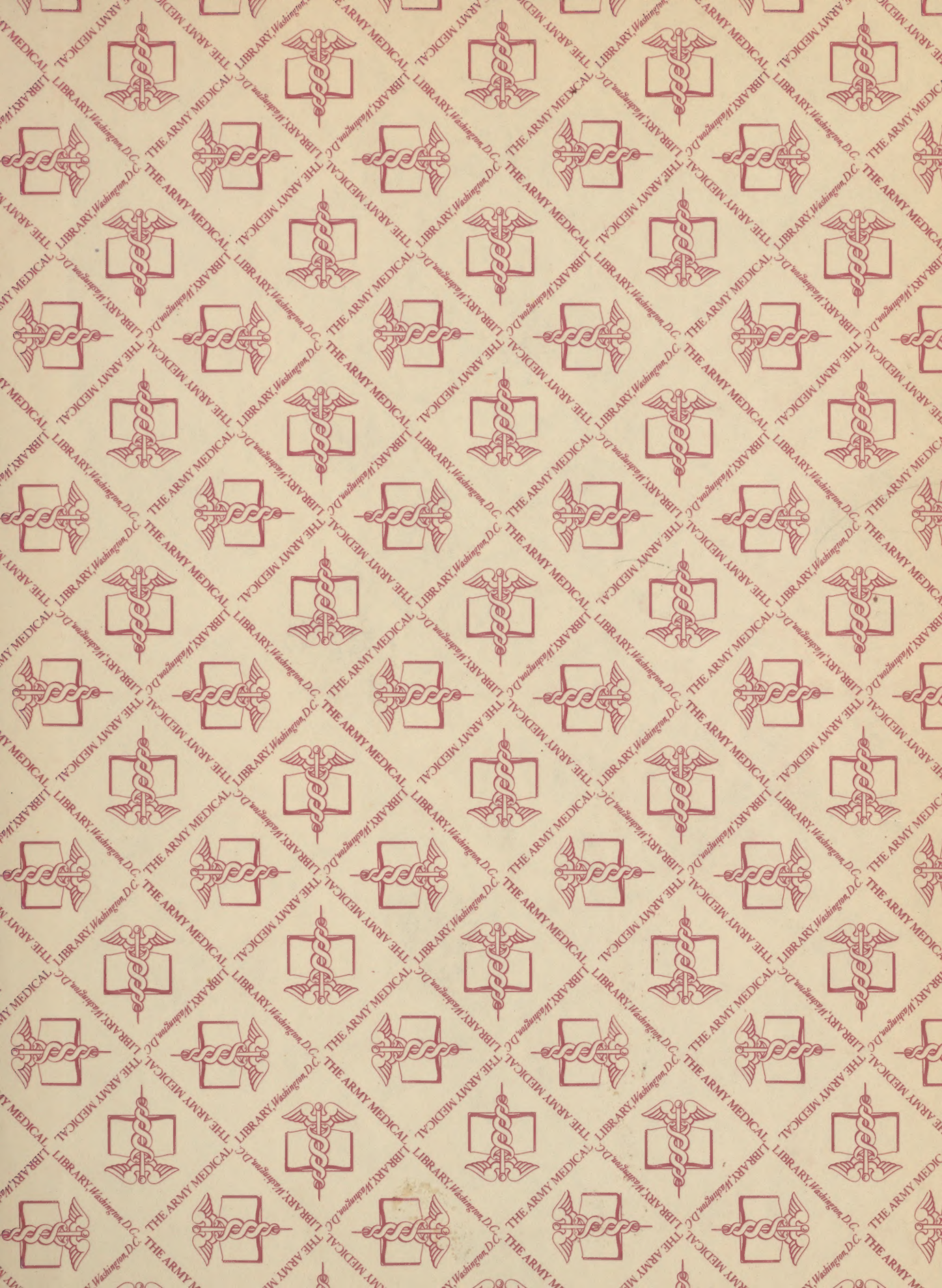
Sec. 4880.23. Rules. The tax commissioner shall prescribe and have printed all needful rules for the enforcement of the provisions of this chapter relating to the assessment, levy and collection of taxes and such rules so made shall have the force and effect of law if they be not in conflict with the express provisions of this chapter or with rules or regulations made by the board pursuant to section 4880.06. Such rules shall also provide for the making of returns concerning, and the payment of, any taxes imposed by this chapter, in any situations not specifically covered by this chapter.

Sec. 4880.24. Tax Commissioner to prescribe forms, etc. The tax commissioner shall prescribe the forms of all returns required to be furnished under the provisions of this chapter and may provide in such forms for the giving of such information as he may deem necessary or advisable. All information required by the form of any return must be included in the return by the person, employer or company responsible for making the same. Every return shall be signed by the person

liable to make the return, or by someone authorized to do so in behalf of such person, all in compliance with rules prescribed by the tax commissioner.

Sec. 4880.25. Penalties. Any person who shall make any false statement or representation or knowingly fail to disclose a material fact to obtain any benefit or advantage pursuant to the provisions of this chapter, or who shall wilfully violate any provision of this chapter or any rule or regulation of the board, or who shall wilfully aid, abet or assist in any manner whatsoever any person to commit any act constituted a misdemeanor by this chapter, shall be guilty of a misdemeanor and, upon conviction thereof, shall be sentenced to pay a fine of not more than $1000 or to imprisonment for a term not exceeding one year, or both, in the discretion of the court."

Section 2. This Act shall take effect upon its approval.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